

**Physician's Prior Authorization Questionnaire
Cimzia®**

Patient:

ID#:

DOB:

Patient Address:

Cimzia® is covered under certain clinical conditions. The following information will help determine if this patient is eligible for coverage of treatment with this drug.

1. What is the patient's diagnosis? *(No codes please.)* _____
2. Is the disease moderate to severe? Yes No
3. Is this being used as first line therapy? Yes No
4. Will the patient be taking any other biological medications at this time? Yes No

Cimzia® will be shipped to the patient from our Specialty Pharmacy.

Physician's Signature

Date

Please **Print** Physician's Name & Specialty

Phone Number

Fax Number

Thank you for your assistance and should you have any questions or wish to discuss, please feel free to contact the pharmacy department at (501) 378-3392. For your convenience, you may fax your response(s) back to (501) 378-6980.

Forms are also available online at www.usableadmin.com/providers/PharmacyForms.aspx