



Date \_\_\_\_\_

Client \_\_\_\_\_

### PRIOR AUTH QUESTIONNAIRE - CIMZIA®

<b>M.D. Last Name:</b> _____	<b>M.D. First Name:</b> _____
<b>Physician Phone:</b> _____	<b>Physician Fax:</b> _____
<b>Patient</b> _____	<b>ID#</b> _____ <b>DOB</b> _____

**TO ENSURE PROMPT PROCESSING PLEASE COMPLETE ALL OF THE QUESTIONS.**

**PLEASE NOTE: FOR ALL REQUESTS, PLEASE ATTACH THE MOST RECENT COPY OF THE PATIENT'S PROGRESS NOTES**

1. Please indicate patient's diagnosis:

- Crohn's Disease
- Fistulizing Crohn's Disease
- Other\* \_\_\_\_\_

**\*Note: If "Other" diagnosis is used, please attach a study with efficacy data supporting this request**

2. Is the patient at least 18 years old? **Yes    No**

3. Please check if the patient has tried any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Sulfasalazine | <input type="checkbox"/> azathioprine     | <input type="checkbox"/> oral corticosteroids             |
| <input type="checkbox"/> 5-ASA         | <input type="checkbox"/> 6-mercaptopurine | <input type="checkbox"/> topical (rectal) corticosteroids |

4. Has the patient tested negative for latent TB? **Yes    No**

5. Will CIMZIA® be administered by a Health Professional? **Yes    No**

6. Does the patient have an active infection? **Yes    No**

7. Is the patient also currently being treated with anakinra? **Yes    No**

8. Has the patient been diagnosed with Congestive Heart Failure? **Yes    No**

9. Strength \_\_\_\_\_ SIG: \_\_\_\_\_

Physician Signature or name of person providing answers \_\_\_\_\_

Physician Comments \_\_\_\_\_

Send or Fax completed form to:  
**877-329-7279**

RESTAT  
11900 W. Lake Park Dr.  
Milwaukee, WI 53224

QUESTIONS PLEASE CALL:  
**877-526-9906**

www.restat.com