



Date _____

Client _____

PRIOR AUTH QUESTIONNAIRE - CIMZIA®

M.D. Last Name: _____	M.D. First Name: _____
Physician Phone: _____	Physician Fax: _____
Patient _____	ID# _____ DOB _____

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
P.O. BOX 758
WEST BEND, WI 53095

QUESTIONS PLEASE CALL:
877-526-9906