

Pharmacy Pre-authorization Form: Cimzia

Note: USE THIS FORM ONLY when seeking pre-authorization for coverage of prescriptions for Cimzia.

Date: _____ Physician Name: _____
 Member Name: _____ Physician Specialty: _____
 Member ID Number: _____ Physician Address: _____
 Member DOB: _____ Physician Telephone: _____
 Physician Fax/E-mail: _____

Diagnosis: _____

ICD9/ICD10 Code(s): _____

****ICD9/ICD10 codes are REQUIRED to process all requests.****

Please answer the questions below and be as specific as possible:

Dose/expected duration of treatment:

Reason for request:

Other medications used to treat condition and dates used:

Please select one of the following:

Doctor (our office) will provide (buy and bill) Cimzia and administer to patient.

Patient will pick up Cimzia at a pharmacy and bring to our office for the doctor to administer.

Patient will pick up Cimzia at a pharmacy and will be taught to self-inject.

For ConnectiCare Use Only

Date reviewed: _____

Approved/denied (circle one) by: _____ Approval expiration date: _____

Comments: _____

ConnectiCare Pharmacy Services: FAX — 1-800-249-1367, or e-mail — pharmacy@connecticare.com
 To speak to a Medical Director or Pharmacist regarding a pre-authorization decision, call 1-800-828-3407.

*This is confidential information. If you receive this form in error, please notify Provider Services immediately at 1-800-828-3407.
 The information in this document does not apply to ConnectiCare VIP Medicare plan members.*