

Cimzia® (certolizumab)



An Independent Licensee of the Blue Cross and Blue Shield Association

Treatment Request (Physician to Complete)

Visit www.wellmark.com for the Wellmark Drug List for current medication tier levels and updated PA Forms

Facsimile Transmittal Sheet

Date: ___/___/___

To: Wellmark Pharmacy Services

From (Prescriber's Name): _____

Fax Number: (866) 884-4345

Prescriber's DEA Number: _____

Phone Number: (800) 600-8065

Prescriber's Phone Number: _____

Prescriber's Specialty: _____ Prescriber's Fax Number: _____

Prescriber's Office Address: _____
Street Suite # City State Zip

Patient Name: _____

Patient ID: _____ Patient DOB: ___/___/___

Please answer the following questions and fax this form back to (866) 884-4345. All fields are REQUIRED.

1. Please provide the diagnosis this therapy has been prescribed for: _____

ICD-9 Code: _____

2. Has the patient shown inadequate response to at least ONE of the following systemic agents? Yes No

Please check all that apply:

- azathioprine methotrexate sulfasalazine
 glucocorticoids 6-mercaptopurine (Purinethol)
 contraindication: _____

3. Has the patient been evaluated for active and latent tuberculosis? Yes No

4. Dose per injection: _____ mg Frequency of injection: _____ per _____

Attach lab results and other documentation as necessary

Printed Name

Signature

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