

**Complete Patient and Physician information (PLEASE PRINT)**

STEP  
1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:

**If Applicable:** Pharmacy Name: \_\_\_\_\_  
 Pharmacy Phone: \_\_\_\_\_

**Complete the Clinical Assessment:**

Diagnosis	<input type="checkbox"/> Moderate to severe active Crohn's Disease	<input type="checkbox"/> Other (please state): _____
Clinical Consideration	Patients should have moderate to severely active disease and be refractory to conventional therapy. <input type="checkbox"/> Patient has tried conventional therapy. Please indicate which: <input type="checkbox"/> Remicade (infliximab) <input type="checkbox"/> Humira* (*Humira is FDA approved for Remicade refractory patients) <input type="checkbox"/> Other: _____	
Physician Specialty	<input type="checkbox"/> Physician experienced with Cimzia therapy <input type="checkbox"/> Gastroenterology <input type="checkbox"/> Other (please state): _____	
	Diagnosis: ICD-9 Code # / Description (required):  Please provide ALL of the information below: Cimzia <sup>®</sup> (certolizumab pegol) Indication and directions for use: _____ _____ _____ _____	
	Please attach all relevant medical records and test results. <b>Incomplete forms will not be processed.</b>	

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

STEP  
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\_\_\_\_\_  
 Prescriber Signature

\_\_\_\_\_  
 Date

STEP  
4

**Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:  
 970-248-5034**

Pharmacy Technician initials: \_\_\_\_\_ Date: \_\_\_\_\_

**Confidentiality Notice:**

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