



**PRIOR AUTHORIZATION REQUEST FORM**  
**Crohn's Disease & Ulcerative Colitis**  
 (Cimzia, Humira, Remicade, Tysabri, Simponi, Entyvio)

**DATE OF REQUEST:** \_\_\_\_\_

**MEMBER INFORMATION**

NAME \_\_\_\_\_

ID # \_\_\_\_\_

BIRTHDATE \_\_\_\_\_

**PLEASE NOTE:** By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

**PRESCRIBING PHYSICIAN INFORMATION**

NAME \_\_\_\_\_

NPI # \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE # \_\_\_\_\_ FAX # \_\_\_\_\_

CONTACT NAME \_\_\_\_\_

PROVIDER SIGNATURE \_\_\_\_\_

Cimzia (not self-administered)     Cimzia (self-administered)     Humira     Remicade     Tysabri

Simponi     Entyvio

**Dose/frequency:** \_\_\_\_\_

If *not* obtained at a pharmacy for self administration:

Obtain at MVP's specialty pharmacy (Caremark) to be shipped to the office for administration

(Circle One) Office/Hospital/Infusion Center: Other \_\_\_\_\_

Facility Name \_\_\_\_\_ Facility NPI \_\_\_\_\_

**Diagnosis** \_\_\_\_\_ **ICD-10 code** \_\_\_\_\_

**Please check one**     **Initial Request**     **Extension Request**

**MOST RECENT ENDOSCOPY REPORT MUST BE SENT WITH THIS REQUEST**  
**THE FOLLOWING INFORMATION MUST BE COMPLETED IN FULL**  
 IF FISTULIZING CROHN'S DISEASE, HOW LONG HAS MEMBER BEEN SYMPTOMATIC: \_\_\_\_\_

LOCATION OF FISTULA: \_\_\_\_\_ BOWEL RELATED ABCESS:  YES  NO

NUMBER OF LIQUID STOOLS/DAY: \_\_\_\_\_ WEIGHT LOSS > THAN 10%:  YES  NO

ANEMIA:  YES  NO    ABDOMINAL MASS:  YES  NO    FEVER:  YES  NO

OVERALL ABDOMINAL PAIN:  NONE     MILD     MODERATE     SEVERE

GENERAL WELL-BEING:  WELL     UNDERPAR     POOR     VERY POOR     TERRIBLE

EXTRA-INTESTINAL SYMPTOMS (PROVIDE DOCUMENTATION):  YES  NO

ESR: \_\_\_\_\_ HCT: \_\_\_\_\_ TB SKIN TEST: \_\_\_\_\_ HISTORY OF CHF  YES (indicate class) \_\_\_\_\_  NO

**LIST CURRENT AND PAST THERAPY AND PATIENT RESPONSE BELOW:**

**PLEASE NOTE:** ALL CHART NOTES/LAB REPORTS IN REFERENCE TO THIS REQUEST MUST BE RECEIVED

**FAX THIS REQUEST TO:**  
 Commercial **1-800-376-6373**  
*(HMO, EPO/PPO, Exchange, Medicaid, Child Health Plus, ASO)*

Medicare Part D **1-800-401-0915**  
*(Preferred Gold, Gold PPO, GoldValue, BasiCare, USA Care, MVP RxCare)*