RESTORE HEALTH
INFUSION AND WELLNESS

CIMZIA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, TB Test

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ **DOB:** _____ **Gender:** ☐M ☐F ☐Other _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

PRESCRIBER INFORMATION

Prescriber Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL INFORMATION

Diagnosis: ☐K51.9 (Ulcerative Colitis) ☐K50.9 (Crohn's Disease) ☐ L40.0 (Psoriasis Vulgaris)
☐ M06.00 (Rheumatoid Arthritis w/o RF) ☐M45 (Ankylosing Spondylitis) ☐ Other: _____

Allergies: _____ **Weight:** _____ ☐Kg ☐Lbs **Height:** _____ ☐cm ☐in

TB/PPD test: ☐Positive ☐ Negative **HBV:** ☐Yes ☐No If yes, treated: ☐Yes ☐No

TREATMENT INFORMATION

CIMZIA (certolizumab pegol)

Route: Subcutaneous injection

Dose: ☐200mg ☐400mg

Frequency:

☐Induction: 400mg SC at weeks 0, 2, and 4

☐Maintenance: Once every ____
- ☐ 2 weeks
- ☐ 4 weeks

Quantity: _____ **Refills:** ____

Premedication Protocol: *(Not Usually Recommended)*

☐ Diphenhydramine: ☐25mg ☐50mg ☐PO ☐IV

☐ Acetaminophen: ☐325mg ☐500mg ☐650mg PO

☐ Other: _____

Sig: _____

Special Instructions: _____

_____

_____

_____

Provider Name: _____ **Provider Signature:** _____ **Date:** _____