

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: _____

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