

CIMZIA (CERTOLIZUMAB PEGOL)

Order Form

			PHONE 515.225.2930 FAX 515.559.2495			
Patient Information	ı			Demog	raphics Attached	
Patient Name:			DOB:	Phone:		
INSURANC	E INFORMATION: Please	attach a copy of pre		lical card(s) (front a	nd back).	
Medical Informatio	n					
Patient Weight:	lbs. Allergies:					
J Code: J0717						
Diagnosis:						
Crohn's disease (ICD-10) Code:)	Plaque psor	iasis (ICD-10 Code:)		
Psoriatic arthritis (ICD-	10 Code:)	Non-radiogr	aphic axial spondylo	parthritis		
Rheumatoid arthritis (I	CD-10 Code:)	(ICD-10 Code	e:)			
Ankylosing spondylitis	(ICD-10 Code:)	Other:				
Required labs: TB (QFT o	r PPD), Hep B surface antigen and H	ep B core AB total				
Clinical/progress notes	, labs and tests supporting primary c	liagnosis attached				
Labs: Required labs to be	e drawn by: Infusion Clinic R	referring Physician				
Lab Orders:						
Cimzia Orders						
Crohn's Disease						
	g subcutaneously at weeks 0, 2 and 4	/,				
	400 mg subcutaneously every 4 we					
	kylosing Spondylitis/Spondyloarth					
	g subcutaneously at weeks 0, 2 and 4					
Maintenance Dose:	200 mg subcutaneously every 2 we	eeks				
Psoriasis	400 mg subcutaneously every 4 w	eeks				
	eously every 2 weeks					
200 mg every 2 we						
400 mg subcutane	eously at weeks 0, 2 and 4, followed b	y 200 mg every 2 weeks				
Additional Orders/Comn	nents:					
Physician Informat						
	utilizing our services, you are authori ng with medical and prescription ins		mployees to serve a	s your prior authorization a	nd specialty pharmacy	
Provider Name:		Signature:		Date		
Provider NPI:	Phone:	Fax:		Contact Person:		
Service Areas						
Des Moines, IA	West Des Moines, IA	Chicago, IL	Omaha, NE	Buffalo, NY	Dallas, TX	
Phoenix, AZ	Other					

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