

INFUSION ORDERS-CIMZIA (CERTOLIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose or Frequency Change <input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: <https://metroinfusioncenter.com/infusion-center-locations/>

Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Active Ankylosing Spondylitis	ICD 10 Code: M45.9
<input type="checkbox"/> Active Axial Spondyloarthritis	ICD 10 Code: M47.9
<input type="checkbox"/> Active Psoriatic Arthritis	ICD 10 CODE: L40.52
<input type="checkbox"/> Moderate to Severe Plaque Psoriasis	ICD 10 CODE: L40.0
<input type="checkbox"/> Moderate to Severe Crohn's Disease	ICD 10 CODE: K50.90
<input type="checkbox"/> Other: _____	ICD 10 CODE: _____
<input type="checkbox"/> Moderate to Severe Rheumatoid Arthritis	ICD 10 CODE: M06.9
Has the patient had failure or contraindication to at least 12 weeks of at least one DMARD? <input type="checkbox"/> YES <input type="checkbox"/> NO	

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics AND insurance information <input type="checkbox"/> Hepatitis B Test Results: HBsAg, Total HepB Core Antibody	<input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Labs and Tests supporting primary diagnosis <input type="checkbox"/> TB Test Results
List Tried & Failed Therapies, including duration of treatment:	
1)	
2)	

MEDICATION ORDERS	
Dosing	Please indicate frequency in blank space provided. <input type="checkbox"/> Cimzia 200mg SubQ _____ <input type="checkbox"/> Cimzia 400mg SubQ _____ <input type="checkbox"/> Other: Cimzia _____ mg SubQ _____
Refills:	<input type="checkbox"/> X 6 months <input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

PRESCRIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record. Contact us with questions at: (877) 448-3627 Fax Completed Form and all documentation to: 866-507-1164