CIMZIA (CERTOLIZUMAB PEGOL) SUB-Q Orders

T: 832.939.8137 **Address: 12144 Dairy Ashford Rd., Suite 100, Sugar Land, TX 77478** **F: 832.939.8128**

PATIENT INFORMATION

Patient Name: ______________________________ Social Sec #: ____________ Weight: ____ lbs

D.O.B: ____________ Sex: Male ____ Female _____ Height: ____ lbs

Phone: __________________

Address: ____ City: __________ State: ____ Zip Code: __________

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

JCode: J0717 **Diagnosis**

- ☐ Crohn's Disease (ICD-10 Code:____________)
- ☐ Psoratic Arthritis (ICD-10 Code:____________)
- ☐ Rheumatoid Arthritis (ICD-10 Code:____________)
- ☐ Ankylosing Spondylitis (ICD-10 Code:____________)
- ☐ Other:____

Allergies: ____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: ____

CIMZIA ORDERS

CIMZIA ☐ Initial Dose: 400mg Sub-Q at weeks 0, 2 and 4 **Maintenance** ☐ 200mg Sub-Q evey two week
☐ Other ________ mg every 4 weeks ☐ 400mg Sub-Q evey four week

☐ TB and Hepatitis B documentation attached ☐ Perform TB testing

TB Protocol Baseline testing: Quantiferon Gold (QFT Gold) or PPD ☐ Yearly TB Screening (*optional)*

Hepatitis B Protocol Hep B surface antigen and Hep B Core AB total required

*Date of last ☐ Remicade ☐ Orencia ☐ Humira ☐ CIMZIA dose:____________

Additional Orders/Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing ur services, you are authorizing DeliverIt Pharmacy infusion Center LLC and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: ____________________________________ Date: ____________________

Physician Name: ______________________________________

Phone: __________________ Fax: ___________________ Contact Person: ______________________