Intravene – Cimzia Order Form (rev 10/2015)

Please fax this form along with a copy of insurance cards and clinical documentation to: (434)455-5531 or call (434) 947-3900 ext. 2172

PATIENT INFORMATION

Name _____
Address _____
City _____
State _____ **Zip Code** _____
Home Phone # _____
Work Phone # _____
DOB _____**SSN** _____
Height _____ **Weight** _____**lbs**
Drug Allergies_____
_____
□ **NKDA** **Sex:** □ **Male or** □ **Female**

REFERRING PHYSICIAN INFORMATION

Physician Name _____
Physician Address_____
Physician City_____
Physician State _____ **Zip Code** _____
Physician Phone(_____)_____
Physician Fax(____)_____
NPI#_____**DEA#**_____
State License#_____

****Please fax copies of insurance cards**
and this form to 434-455-5531

Diagnosis Code: primary (ICD-10 required)

☐ _____ _____
☐ _____ _____
☐ _____ _____

PRE TREATMENT SCREENING:

Tuberculosis Screening: Date/Results of TB test_____
Hepatitis B Screening: Date/ Results:_____
Hepatitis C Screening: Date/Results:_____

Medical Information:

Prior history:	**Prior biologic use:**	**Date of last dose:**
□ **5-ASA**	□ **Remicade**	_____
□ **Immunosuppressants**	□ **Enbrel**	_____
□ **Corticosteroids**	□ **Humira**	_____
□ **Methotrexate**	□ **Orencia**	_____
□ **Surgery**	□ **Simponi Aria**	_____
□ **Other**_____	□ **Rituxan**	_____
□ **Other**_____	□ **Actemra**	_____
□ **Other**_____	□ **CIMZIA**	_____

Cimzia-Dosing (Lyophilized Powder)

Initial Dosing:
□ **Initial dose of 400mg SC at weeks 0, 2 and 4**

Maintenance Dosing (please select the Appropriate schedule
□ **200mg SC every 2 weeks** **Refills:** □ **24 (1 year)** □ **Other**_____
□ **400mg SC every 4 weeks** **Refills:** □ **12 (1 year)** □ **Other**_____

Signature, prescribing MD _____ **Date** _____