Intravene – Cimzia Order Form- Psoriasis (rev 4/2022)

Please fax this form along with a copy of insurance cards and clinical documentation to: (434)455-5531 or call (434) 947-3900 ext. 3001

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:**
□ Immunosupprants	**□ Remicade**	_____
□ Corticosteroids	**□ Enbrel**	_____
□ Methotrexate	**□ Humira**	_____
	□ Stelara	_____
	□ Simponi	_____

□ Other_____

Cimzia-Dosing (Lyophilized Powder) Initial
Dosing:
□ 400mg SC every 2 weeks **Refills: □ 24 (1 year)** **□ Other**_____

ANAPHYLACTIC MEDS AND VIAL SIGNS MONITORING PER INTRAVENE PROTOCOL

Signature, prescribing MD _____ **Date** _____