Intravene – Cimzia Order Form (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:
□ 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_____

ANPHYLACTIC MEDS AND VITAL SIGNS MONITORING PER INTRAVENE PROTOCOL

Signature, prescribing MD _____ Date _____