Phone: (833) 394-0600 Fax: (833) 996-4888

Cimzia subcutaneous injection

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: ____ **DOB**: _____/_____/_____

Allergies: ___________________________ **Patient Weight:** ________lbs / kg **Height:**___________

ICD-10 : ______________________, __________________________, _________________________

Will the patient be receiving other biologic therapy in combination with Cimzia? ☐ No ☐ Yes
*If yes to above, please provide rational for use:*____

In the past year, what medications for the above diagnosis has the patient tried and failed?
☐ N/A continuation of treatment

Drug	Dose	Dates of use

TB verification ***(circle one):*** **TB skin test** **TB spot/Quantiferon blood test** **Chest X-RAY**

Result Date: ________/_______/__________ Result ***(circle one):*** **Positive** **Negative**

Cimzia (certolizumab pegol) subcutaneous injection

Dose: ☐ 200mg ☐ 400mg ☐ Other: ___________________

Frequency: **☐ Initial dose 0, 2 weeks, 4 weeks THEN**

Maintenance dosing: ☐ q2 weeks ☐ q4 weeks

Date of last injection if not at IA:_____________________ **Expiration Date:** _____/_____/_____

Printed Provider Name: ____

Provider Signature: ____

Office Phone Number: ______________________**Office Fax Number:** ________________________

Contact Name: _________________________**Contact Phone Number:** _______________________

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐TV/streaming ☐ Other: ________