☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

(certolizumab pegol)

CIMZIA infusion orders

Date: _____

Mission Medical

Patient Name _____ DOB _____

Phone _____ M ○ F ○

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Rheumatoid Arthritis
☐ _____ Crohn's Disease
☐ _____ Ankylosing Spondylitis
☐ _____ Psoriatic Arthritis
☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____ *(other)*
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ *(other)*

CIMZIA ORDERS

DOSAGE/FREQUENCY

☐ 400mg SQ initially and at Weeks 2 and 4 *(induction)*

○ 200mg SQ every 2 weeks
○ 400mg SQ every 4 weeks *(maintenance)*

PATIENT WEIGHT

_____ lbs.
_____ kg

TB TESTING

○ Perform Quantiferon Gold (QFT Gold)
○ Perform PPD Skin Test

NOTES

_____

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____