

Lexington
1792 Alysheba Way
Suite 205
Lexington, KY 40509

Bowling Green
727 U.S. 31 W Bypass
Suite 102
Bowling Green, KY 42101



(certolizumab pegol)

CIMZIA infusion orders

Date: _____

PATIENT INFORMATION		
Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

DIAGNOSIS <i>Please provide ICD-10 code</i> ☐ _____ Rheumatoid Arthritis ☐ _____ Crohn's Disease ☐ _____ Ankylosing Spondylitis ☐ _____ Psoriatic Arthritis ☐ _____ (other) PRE-MEDICATION ☐ Tylenol 1000mg PO ☐ Solu-Medrol 125mg IVP ☐ Diphenhydramine 25mg PO ☐ Solu-Cortef 100mg IVP ☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg IVP ☐ _____ (other) ☐ _____ (other)	CIMZIA ORDERS PATIENT WEIGHT _____ lbs. _____ kg DOSAGE/FREQUENCY: ☐ 400mg SQ initially and at Weeks 2 and 4 (induction) ☐ 200mg SQ every 2 weeks (maintenance) ☐ 400mg SQ every 4 weeks TB TESTING ☐ Perform QuantiFERON Gold (QFT Gold) ☐ Perform PPD Skin Test
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NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____