Cimzia® (certolizumab pegol) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
3.TB screening and Hepatitis B vaccine or testing documentation.

____ ______________________
Patient Name **DOB**

________________________________ ___________________________
Allergies **Patient Phone**

Diagnosis (must include ICD10 code)
☐ Rheumatoid Arthritis _______________ ☐ Psoriatic Arthritis_______________
☐ Ankylosing Spondylitis_______________☐ Crohn's Disease_______________
☐ Other (ICD-10 Code):_________________________________

Prescription Orders: Cimzia® (certolizumab pegol) 200mg lyophilized powder

☐ **Initial Dosing**: 400mg (divided into two doses) Sub-Q at weeks 0, 2 and 4

☐ **Maintenance Dosing**: ☐ 200 mg Sub-Q every 2 weeks
☐ 400 mg (divided into two doses) Sub-Q every 4 weeks

Refills: ☐ 12 months or ☐ _________injections

____
Physician Name **Phone** **Fax**

____
Physician's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com

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