PURE INFUSION SUITES

Fax form to:
Billings - 719.300.4068
Great Falls - 406.384.7002
Boise - 208-488-4998
Colorado Springs - 719.300.4068
Grand Junction - 970.822.7700

INFUSION ORDERS CIMZIA (certolizumab pegol)

Patient's Information

Date of Referral

First Name | Last Name | M.I.

Date of Birth

Address

City | State | ZIP Code

Phone

WT (kg) | HT (in)

Diagnosis

☐ Rheumatoid Arthritis

☐ Crohn's Disease

☐ Other:

Allergies

***Please fax all recent labs including TB date/results and Hepatitis B results.**

*ICD 10 CODE

***Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

CIMZIA LyOPHILIZED DOSING

Initial Dose

☐ 400mg SC at weeks 0, 2, and 4

Maintenance Dose (Please Select Appropriate Schedule)

☐ 200mg SC every 2 weeks

Refills:

OR

☐ 400mg SC every 4 weeks

Refills:

Prescribing Provider

Address

City | State | ZIP Code

Provider Signature

Date

Provider Phone | Provider Fax