PURE
INFUSION SUITES

Fax form to:
Billings - 406.206.0105
Great Falls - 406.794.0555
Boise - 208.545.3214
Colorado Springs - 719.623.0085
Grand Junction - 970.404.8100

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