

Fax form to:

CO - Colorado Springs - 1.719.623.0085 ID - Boise - 1.208.545.3214
 CO - Grand Junction - 1.970.404.8100 ID - Twin Falls - 1.208.487.7679
 CO - Lone Tree - 1.720.246.2925 MT - Billings - 1.406.206.0105
 FL - Bonita Springs - 1.239.237.5547 MT - Great Falls - 1.406.794.0555
 FL - Jacksonville - 1.904.830.0718 UT - Salt Lake City - 1.801.852.0999

**INFUSION ORDERS CIMZIA
(certolizumab pegol)**

Note: you must enter a 1 before the fax number

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**

U F N F

Provider Phone

Provider Fax