ADDRESS: 12144 DAIRY ASHFORD RD. SUITE 100 SUGAR LAND, TX 77478

DELIVERIT
Infusion & Specialty

CIMZIA (CERTOLIZUMAB PEGOL) SUB-Q ORDERS

PHONE: (832) 939-8137
FAX: (832) 939-8128

☐ **Infused at MDO.**

☐ **Infused at Home.** SET UP OF SKILLED NURSING VISITS REQUIRED.

COMPLETE PATIENT DEMOGRAPHIC INFORMATION IN SECTION BELOW

Or Attach Face Sheet from Patient Chart

Patient Name:		DOB:	Gender: ☐ Male ☐ Female	Weight:	☐ lbs ☐ kg
SSN:	Phone:	Allergies:			
Address:		City:	State:	Zip code :	

COMPLETE PATIENT INSURANCE INFORMATION IN THE SECTION BELOW

Or Attach Copies of Patient's Insurance Card

Primary insurance Carrier:	Name of the Insured:	Relationship:
Member ID #:	Group #:	Insurance Phone #:
Secondary Rx Carrier Name:	Rx ID #:	Rx Group #:

MEDICAL INFORMATION

JCode: J0717 Diagnosis

☐ Crohn's Disease (ICD-10 Code:_____)

☐ Psoratic Arthritis (ICD-10 Code:_____)

☐ Rheumatoid Arthritis (ICD-10 Code:_____)

☐ Ankylosing Spondylitis (ICD-10 Code:_____)

☐ Other:_____

Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Labs Orders: _____

CIMZIA ORDERS

CIMZIA ☐ Initial Dose: 400mg Sub-Q at weeks 0, 2 and 4

☐ Other _____ mg every 4 weeks

Maintenance ☐ 200mg Sub-Q evey two week

☐ 400mg Sub-Q evey four week

☐ TB and Hepatitis B documentation attached ☐ Perform TB testing

TB Protocol Baseline testing: Quantiferon Gold (QFT Gold) or PPD ☐ Yearly TB Screening (optional)

Hepatitis B Protocol Hep B surface antigen and Hep B Core AB total required

*Date of last ☐ Remicade ☐ Orencia ☐ CIMZIA dose:_____

Additional Orders/Comments: _____

COMPLETE PRESCRIBER INFORMATION IN SECTION BELOW

Prescriber Name:	NPI#:	Office#:	Fax#:
Address:	City:	State:	Zipcode:

SIGNATURE OF LICENSED PRESCRIBER (REQUIRED TO VALIDATE PRESCRIPTION)

☐ I Authorize DeliverIt specialty pharmacy to initiate Prior Authorizations on my behalf.

Prescriber's Signature:

X_____

☐ DAW(Dispense as Written)

Date: _____

Prescriber certifies that this referral form contains an original signature and is signed by the treating prescriber. No stamped signatures will be accepted. Where required by law, send electronic prescription or on official state prescription blank. In the event requested agent is not available through DeliverIt Group, this prescription shall be forwarded to an eligible pharmacy.