CIMZIA (CERTOLIZUMAB PEGOL)

SUB-Q ORDERS

DELIVERIT™ Infusion & Specialty
Phone +1.832.939.8137
Fax: +1.832.939.8128

Patient Demographic Information

(Or Attach Face Sheet from Patient Chart)

Patient Name		DOB		Gender	Male ☐ Female ☐	Weight	____lbs ☐ kg ☐
SSN		Phone		Allergies			
Address		City		State		Zip Code	

Patient Insurance Information

(Or Attach Copies of Patient's Insurance Card)

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

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Prescriber Insurance Information

Prescriber Name		**NPI#**		**Office #**		**Fax #**	
Address		**City**		**State**		**Zip Code**	

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

☐ DAW (Dispense as written).

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.

Date

Prescriber's Signature

X _____

Please fax all information to (877)993-3548 or call (832)939-8128 for assistance

Our local number 832-939-8137