

Cimzia® (certolizumab pegol) Order Form

Please include the following (required):

1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
3. TB screening and Hepatitis B vaccine or testing documentation.

Patient Name

DOB

Allergies

Patient Phone

Diagnosis (must include ICD10 code)

- Rheumatoid Arthritis _____ Psoriatic Arthritis _____
 Ankylosing Spondylitis _____ Crohn's Disease _____
 Other (ICD-10 Code): _____

Prescription Orders: Cimzia® (certolizumab pegol) 200mg lyophilized powder

- Initial Dosing:** 400mg (divided into two doses) Sub-Q at weeks 0, 2 and 4
- Maintenance Dosing:** 200 mg Sub-Q every 2 weeks
 400 mg (divided into two doses) Sub-Q every 4 weeks

Refills: 12 months or for _____ injections

Provider Name

Phone

Fax

Provider's signature

Date

**Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com**