immersiv HEALTH

CIMZIA® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

- ☐ K50.00 Crohn's Disease – small intestine
- ☐ K50.10 Crohn's Disease – large intestine
- ☐ K50.80 Crohn's Disease – small & large intestine
- ☐ K50.90 Crohn's Disease, unspecified
- ☐ L40.0 Psoriasis vulgaris
- ☐ L40.5__ Psoriatic Arthritis (PsA)
- ☐ L40.9 Psoriasis, unspecified
- ☐ M05.___ Rheumatoid Arthritis with rheumatoid factor
- ☐ M06.___ Rheumatoid Arthritis without rheumatoid factor
- ☐ M45.___ Ankylosing Spondylitis (AS)
- ☐ M45.A__ Non-Radiographic Axial Spondyloarthritis (nr-axSpaA)
- ☐ M46.8__ Other specified inflammatory spondylopathies

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Tried & Failed Therapies ☐ Most Recent History & Physical ☐ Negative TB screening

MEDICATION ORDER

☐ **LOADING:** Cimzia® (certolizumab pegol) 400mg subcutaneous injection at week 0, week 2 and week 4

☐ **MAINTENANCE:** Cimzia® (certolizumab pegol) 200mg subcutaneous injection every 2 weeks

☐ **MAINTENANCE:** Cimzia® (certolizumab pegol) 400mg subcutaneous injection every 4 weeks

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ | _____ **DATE:** _____
(NO STAMPS)
SUBSTITUTION PERMITTED DISPENSE AS WRITTEN