

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. Administer per protocol.
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