CIMZIA® Infusion Form

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ○ M ○ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ○ N ○ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

_____ Crohn's Disease
_____ Rheumatoid Arthritis
_____ Ankylosing Spondylitis
_____ Psoriatic Arthritis
_____ Other: _____

Infusion Center – Lab Orders (Check order for Infusion Center to manage):

☐ Obtain liver enzymes at baseline and every six months thereafter

Please attach the following: 1. List of current Medications, including therapies trialled and or failed and date of last infusion:

○ **Remicade** ○ **Orencia** ○ **Humira** ○ **Cimzia** **Date:** _____

2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs 5. Hepatitis B Screening Results (surface antigen) 6. TB Screening Documentation - Date of most recent screening: _____

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **CIMZIA® (certolizumab pegol)**

New Start:

Cimzia 400 mg subcutaneously on week 0, 2 and 4 3 Doses Authorized

Maintenance Regimen:

☐ Cimzia 200 mg subcutaneously every other week _____ # Refills (Recommend 12 Refills)
☐ Cimzia 400 mg subcutaneously every four weeks _____ # Refills (Recommend 06 Refills)

Pre-Medication Orders: No Pre-Meds recommended

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date