INTRAMED Plus
infusion services

CIMZIA®

INFUSION & MEDICAL CENTER

1. Patient Name ______________________ **DOB** __________ **Patient Phone/Cell #** ______________

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis:
- ________Crohn's Disease — ICD-10 Code: K50. __________
- ________Rheumatoid Arthritis — ICD-10 Code: M0. __________
- ________Psoriatic Arthritis — ICD-10 Code: L40.5__________
- ________Ankylosing Spondylitis — ICD-10 Code: M45. __________
- ________Other: ______________________ — ICD-10 Code: __________

Allergies:____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
- Previous Drug Therapy History, including therapies trialed and or failed and date of last infusion:
  ❏ Remicade ❏ Orencia ❏ Humira ❏ Cimzia Date:______________
- Hepatitis B Screening Results (surface antigen)
- TB Screening Documentation
  Date of most recent screening:______________

Patient
Weight: __________ lbs.
Height:__________ in.

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

❏ Obtain liver enzymes at baseline and every six months thereafter

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CIMZIA® (certolizumab pegol) J Code: J0717

4. Drug Order:

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

Maintenance Dose:

- ❏ Cimzia 200 mg subcutaneously every other week ________ # Refills (Recommend 12 refills)
- ❏ Cimzia 400 mg subcutaneously every four weeks ________ # Refills (Recommend 6 refills)

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

By signing this form and utilizing these services, I am authorizing Intramed Plus
to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: ______________________ / ______________________ Date: __________
Dispense as written Substitution permitted

Printed Physician's Name:______________________Contact Phone #: ______________

FAX ALL INFORMATION CENTRAL FAX **803.999.1754** ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337

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