

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

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	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1760
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