CIMZIA (CERTOLIZUMAB PEGOL) Order Form

WWW.PACEINFUSION.COM
PH:330-625-4900
F: 330-685-9355

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Rqd.)* ☐ Verify Benefits Only ☐ D/C Infusions **indicate name of drug(s)*

PACE Healthcare can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____

DOB: _____

Phone # _____

Email: _____

Insurance ID #: _____

PRESCRIBER INFORMATION

Referring Physician: _____

Address: _____

_____

Office Contact: _____

Phone # & Ext.: _____ _____ Fax #: _____

Direct Message Address

CIMZIA MEDICATION ORDERS

☐ Initial/Reload Dosing:_____ mg injection on day 0, 2 weeks, 4 weeks then every _____weeks.

☐ Maintenance Dosing: _____ mg injection every_____ weeks.

DIAGNOSIS/INDICATION

☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified
☐ M06.9 Rheumatoid arthritis, unspecified
☐ K50.90 Crohn's disease, unspecified, without complications
☐ K50.00 Crohn's disease of small intestine
☐ Other *(please specify in notes)*

***ICD-10** _____ **required**

NOTES (ADDITIONAL INFO)

_____
Ordering Provider's Signature

_____
Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

PLEASE ATTACH THE FOLLOWING REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ HepB Surf Ag (w/in 12 months) ☐ HepB Core Ab (w/in 12 months) ☐ PPD Results (w/in 12 months)
☐ Chest X-ray (if indicated) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY