PARAGON INFUSION CENTERS

CIMZIA (CERTOLIZUMAB PEGOL) SUB-Q ORDERS

PATIENT INFORMATION

☑ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION /MEDICAL CARD(S), FRONT AND BACK

MEDICAL INFORMATION

J Code: J0717 Diagnosis:
- ☐ Crohn's Disease (ICD-10 Code: _____)
- ☐ Psoriatic Arthritis (ICD-10 Code: _____)
- ☐ Rheumatoid Arthritis (ICD-10 Code: _____)
- ☐ Ankylosing Spondylitis (ICD-10 Code: _____)
- ☐ Other: _____

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

CIMZIA ORDERS

Cimzia ☐ Initial Dose: 400mg Sub-Q at weeks 0, 2, and 4 weeks

Maintenance Dose: ☐ 200mg Sub-Q every two weeks

☐ 400mg Sub-Q every four weeks

☐ Other _____ mg every 4 weeks

☐ TB and Hepatitis B documentation attached ☐ Perform TB testing

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(Optional)*

Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required.

* Date of last ☐ Remicade ☐ Orencia ☐ Humira ☐ Cimzia dose: _____

Additional Orders/Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc.and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS

Phone: 877-365-5566 **Fax: 855-889-2946**	**Texas** ☐ Arlington ☐ Austin ☐ Dallas ☐ Houston ☐ North Hills ☐ Plano ☐ Round Rock ☐ San Antonio ☐ Stone Oak	**Tennessee** ☐ Knoxville	**Georgia** ☐ Atlanta

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