



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 Maintenance Dose: 200mg Sub-Q every two week
 Other _____ mg every 4 weeks 400mg Sub-Q every four 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 LOCATION

- | | | | | | | | | | |
|------------------------------------|---------------------------------|---------------------------------|----------------------------------|------------------------------------|--------------------------------------|--------------------------------|-------------------------------------|--------------------------------------|------------------------------------|
| <input type="checkbox"/> Arlington | <input type="checkbox"/> Austin | <input type="checkbox"/> Dallas | <input type="checkbox"/> Houston | <input type="checkbox"/> Knoxville | <input type="checkbox"/> North Hills | <input type="checkbox"/> Plano | <input type="checkbox"/> Round Rock | <input type="checkbox"/> San Antonio | <input type="checkbox"/> Stone Oak |
| P: 817.200.2530 | P: 512.261.4800 | P: 972.408.2777 | P: 713.860.1755 | P: 865-299-7525 | P: 817.284.2700 | P: 469-974-0565 | P: 737-443-5230 | P: 210.366.4358 | P: 210.485.3700 |
| F: 817.509.0011 | F: 512.261.4803 | F: 469.913.6894 | F: 713.277.7219 | F: 865-338-5604 | F: 817.284.2701 | F: 469-608-2072 | F: 737-402-7698 | F: 210.366.4896 | F: 210.390.1738 |

ParagonHealthcare.com

IMPORTANT NOTICE: This fax is intended to be delivered only to the named addressee. It contains material that is confidential, privileged property or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute or copy this fax. Please notify the sender immediately. If you have received this document in error and then destroy this document immediately.