Provider Order Form

CIMZIA (CERTOLIZUMAB)



PATIENT					
Full Name:				DOB:	
Mobile Phone:				Weight:	_ lbs kg
Allergies:				NKDA	
Patient status:	☐ New to therapy	☐ Continuing therapy	Last Treatment Date: Next Treatment Date:		
DIAGNOSIS IC	D-10 code (mus	t be specified)			
☐ Rheumatoid Arthritis M05 ☐ Plaque Psoriasis L40.				Crohn's Disease K50	
Psoriatic Arthritis L40.		☐ Ankylosing Spondylitis M45. ☐ Non-radiographic axial spondylarthritis M45.			spondylarthritis M45.A
Other:					
PROVIDER					
Provider Name: F			Provider NPI:		
Practice Name:			Referral Coordinator Name:		
Practice Address: _					
Phone:		Fax:	Emai	l:	
THERAPY AD	MINISTRATION				
MedicationDose⊠ Cimzia (Certolizumab), Subcutaneous Injection□ 200 mg			Frequency Induction: Week 0, 2, 4, and then maintenance		
		☐ 400 mg		☐ Maintenance: Every ☐ Maintenance: Every	
Other:	12 months \square	Order valid for 1 year	unloss othorwise s		
		Jursing Procedures, including			
LABORATORY		,	0 0	1 1	
	_	each dose	every		
☐ CMP ☐ Other	ato	each dose	every		
SPECIAL INST		each dose	☐ every		
SPECIAL INST	RUCTIONS				
DI FACE ATTAC	H THE FOLLOW	NC CO WE CAN MOS	er periolena	UV DDOCECC THE	DATIENT'S ODDED
		NG SO WE CAN MOS			
Patient Demogra	phics Insurance c	ard Progress Notes su	pporting DX \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	TB status results	patitis B status results
Provider Signatu	re		— Date	2	
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пртиле ати со	M Phone (7	24) 202 0476 Ea	w. (000) 272 Fr	T20 Email: m	Samuel Ossatisch auch auch

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