



Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

CIMZIA ORDER

New Start Maintenance: Last Dose Given _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	
Allergies <input type="checkbox"/> NKDA <input type="checkbox"/> Allergies: _____		
Height: _____ Weight: _____		

Indication:

<input type="checkbox"/> M05.79 RA with rheumatoid factor of multiple sites w/o organ involvement	<input type="checkbox"/> M06.09 RA w/o rheumatoid factor, multiple sites
<input type="checkbox"/> L40.50 Psoriatic arthritis	<input type="checkbox"/> M45.9 Ankylosing spondylitis, unspecified site in spine
<input type="checkbox"/> Other _____	<input type="checkbox"/> M45.A6 Non-radiographic axial spondylarthritis of lumbar region
	<input type="checkbox"/> K50__ Crohn's Disease
	<input type="checkbox"/> L40.0 Plaque psoriasis

DOSE:

With Loading Doses: 400mg SQ at weeks 0, 2 and 4 then every 4 weeks - Crohn's

With Loading Doses: 400mg SQ at weeks 0, 2 and 4 then 200mg every 2 weeks - RA, PsA

400mg SQ every other week - plaque psoriasis

Maintenance Only: 400mg SQ every 4 weeks

Maintenance Only: 200mg SQ every 2 weeks

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
 - Insurance card(s) – copy of front & back
 - Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
- Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP TB Hep B Other: _____