

PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ (ft) _____ (in) Allergies: _____	Prescriber Name: _____ State License: _____ NPI #: _____ DEA: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____

INSURANCE INFORMATION – OR – Send a copy of the patient’s prescription/insurance cards (front & back)	
Primary Insurance: _____ City, State, Zip: _____ Plan #: _____ Group #: _____ Phone: _____	RX Card (PBM): _____ BIN: _____ PCN: _____ City, State, Zip: _____ Group #: _____ Phone: _____

CLINICAL INFORMATION	
ICD-10 Code: _____ Secondary ICD-10 Code (if applicable): _____ Diagnosis Description: _____ Drug Allergies: _____	Latex Allergy: <input type="checkbox"/> Yes <input type="checkbox"/> No TB/PPD Test Given: <input type="checkbox"/> Yes <input type="checkbox"/> No Results: _____ Hepatitis B Vaccination: <input type="checkbox"/> Yes <input type="checkbox"/> No Results: _____

CIMZIA® ORDERS			
Medication	Strength/Formulation	Directions	Quantity/Refills
<input type="checkbox"/> Cimzia (Certolizumab Pegol) prefilled syringe starter kit	<input type="checkbox"/> 200 mg (1 mL), 6 prefilled syringes	Inject 400 mg (2 pre-filled syringes) subcutaneously at weeks 0, 2, and 4	
<input type="checkbox"/> Cimzia (Certolizumab Pegol) prefilled syringe	<input type="checkbox"/> 200 mg (1mL), 2 prefilled syringes	<input type="checkbox"/> Inject 400mg SQ every 4 weeks <input type="checkbox"/> Inject 200mg SQ every other week <input type="checkbox"/> Inject 400mg SQ every other week	
<input type="checkbox"/> Cimzia (Certolizumab Pegol) Maintenance Dose	<input type="checkbox"/> 200 mg (1mL) single use vial	<input type="checkbox"/> Inject 400mg SQ every 4 weeks <input type="checkbox"/> Inject 200mg SQ every other week <input type="checkbox"/> Inject 400mg SQ every other week	

ANAPHYLACTIC REACTION (AR):
Epinephrine (based on patient weight) EpiPen® Auto-injector 0.3 mg (1:1000) - Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary EpiPen Jr® Auto-injector 0.15mg (1:2000) - Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg); may repeat in 3-5 mins x 1 if necessary

SIGNATURE
<div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> X _____ Prescriber Signature </div> <div style="width: 30%;"> Date: _____ </div> </div>

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