BioTek reMEDys®

CIMZIA®

Please Fax Completed Form To: 800-783-9146

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____(ft) _____(in)
Allergies: _____

PRESCRIBER INFORMATION

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: _____ RX Card (PBM): _____
City, State, Zip: _____ BIN: _____ PCN: _____
Plan #: _____ City, State, Zip: _____
Group #: _____ Group #: _____
Phone: _____ Phone: _____

CLINICAL INFORMATION

ICD-10 Code:
Secondary ICD-10 Code (if applicable):_____
Diagnosis Description: _____
Drug Allergies: _____

Latex Allergy: ☐Yes ☐No
TB/PPD Test Given: ☐Yes ☐ No Results: _____
Hepatitis B Vaccination: ☐ Yes ☐ No Results: _____

CIMZIA® ORDERS

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

X_____ Date: _____
Prescriber Signature