INTRAMED Plus
infusion services

CIMZIA®

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis:
_____Crohn's Disease — ICD-10 Code: K50. _____
_____Rheumatoid Arthritis — ICD-10 Code: M0. _____
_____Psoriatic Arthritis — ICD-10 Code: L40.5_____
_____Ankylosing Spondylitis — ICD-10 Code: M45. _____
_____Other: _____ — ICD-10 Code: _____

Allergies:_____(or attach list)

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
- Previous Drug Therapy History, including therapies trialed and or failed and date of last infusion:

❑ Remicade ❑ Orencia ❑ Humira ❑ Cimzia Date:_____

- Hepatitis B Screening Results (surface antigen)
- TB Screening Documentation

Date of most recent screening:_____

Patient
Weight: _____ lbs.
Height:_____ in.

Infusion Center – Lab Orders (Check order for Infusion Center to manage):

❑ Obtain liver enzymes at baseline and every six months thereafter

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CIMZIA® (certolizumab pegol) J Code: J0717

4. Drug Order:

Cimzia 400 mg subcutaneously on week 0, 2 and 4 3 Doses Authorized

Maintenance Dose:

❑ Cimzia 200 mg subcutaneously every other week _____ # Refills (ecommend 12 refills
❑ Cimzia 400 mg subcutaneously every four weeks _____ # Refills (ecommend 6 refills

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name:_____Contact Phone #: _____

FAX ALL INFORMATION	CENTRAL INTAKE PHONE
CENTRAL FAX **803.999.1754**	**803.999.1750**