



Birmingham, AL
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Knoxville, TN
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Nashville, TN
F: 615-645-4791

Chantilly, VA
F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F Height: _____ Weight: _____
 Phone Number: _____ Email Address: _____
 Allergies: _____ Is the patient Diabetic: Y N ICD-10 Code: _____
 Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Crohn's Disease
 _____ Rheumatoid Arthritis
 _____ Ankylosing Spondylitis
 _____ Psoriatic Arthritis
 _____ Other: _____

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

Obtain liver enzymes at baseline and every six months thereafter

Please attach the following: 1. List of current Medications, including therapies trialed and or failed and date of last infusion:

Remicade Orencia Humira Cimzia Date: _____

2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs 5. Hepatitis B Screening Results (surface antigen) 6. TB Screening Documentation - Date of most recent screening: _____

Physician Information

Prescribing Physician: _____ Practice Name: _____
 Practice Phone: _____ Practice Fax: _____
 Email: _____ Office Contact: _____
 Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: CIMZIA® (certolizumab pegol)

New Start:

Cimzia 400 mg subcutaneously on week 0, 2 and 4

3 Doses Authorized

Maintenance Regimen:

Cimzia 200 mg subcutaneously every other week
 Cimzia 400 mg subcutaneously every four weeks

_____ # Refills (Recommend 12 Refills)
 _____ # Refills (Recommend 06 Refills)

Pre-Medication Orders: No Pre-Meds recommended

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

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

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

Physician's NPI#

Physician's Address

Prescriber's Signature

Date