CIMZIA® Infusion Form

Fax Referral To: 877-438-9380

CONTINUUMRX Specialty Infusion Services

Birmingham,AL	Huntsville, AL	Knoxville, TN	Nashville, TN	Chantilly, VA
F: 205-271-9971	F: 256-417-6408	F: 865-934-0249	F: 615-645-4791	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 trialled 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 _____ # Refills (Recommend 12 Refills)

☐ Cimzia 400 mg subcutaneously every four weeks _____ # 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. Presriber'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

Legal Notice: The prescriber is to comply with their state specific prescription requirements such as e-prescribing, state specific prescription form, fax language, etc. Non-compliance with state specific requirements could result in outreach to the prescriber. The document(s) accompanying this transmission may contain confidential health information that is legally protected. This information is intended only for the use of the recipient named above. The authorized recipient of this information is prohibited from disclosing this information to any other party unless permitted or required to do so by law or regulation. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents. This prescription may be filled out at a pharmacy of the patient's choice. ©2025 ContinuumRx Services, Inc. All rights reserved.