PREMIER VITALITY

Physician-led · Patient-centered Infusion-care

Please fax completed form, insurance card, and clinical documentation to:
FAX: 410-220-2553

CIMZIA ORDER

☐ **New Start** ☐ **Maintenance: Last Dose Given**_____

Referring Office: Contact Name:	Date:
Direct Phone for Contact:	Fax:
Patient Name:	DOB:

Allergies ☐ NKDA ☐ Allergies:

_____ Height:

_____ Weight: _____

Indication:

☐ M05.79 RA with rheumatoid factor of ☐ M06.09 RA w/o rheumatoid factor, multiple sites multiple sites w/o organ involvement ☐ M45.9 Ankylosing spondylitis, unspecified site in spine ☐ L40.5__ Psoriatic arthropathy ☐ M45.A6 Non-radiographic axial spondylarthritis of lumbar region ☐ Other _____

DOSE:

☐ With Loading Doses: 400mg SQ at weeks 0, 2 and 4 then every 4 weeks
☐ With Loading Doses: 400mg SQ at weeks 0, 2 and 4 then 200mg every 2 weeks
☐ Maintenance Only: 400mg every 4 weeks
☐ Maintenance Only: 200mg every 2 weeks
☐ _____

Prescriber Name:	Title:

NPI:	DEA:

Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive ALL the following:

☐ Face Sheet / Patient Demographics

☐ Insurance card(s) – copy of front & back

☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:

☐ CBC ☐ CMP ☐ TB ☐ Hep B Other: _____