



MEDICATION ORDERS

CIMZIA (CERTOLIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency	<input type="checkbox"/> Change Order Renewal

INFUSION OFFICE PREFERENCE (Optional)	
Preferred Location:	<input type="checkbox"/> Montgomery <input type="checkbox"/> Prattville

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Active Ankylosing Spondylitis	ICD 10 Code: M45.9
<input type="checkbox"/> Active Axial Spondyloarthritis	ICD 10 Code: M47.9
<input type="checkbox"/> Active Psoriatic Arthritis	ICD 10 CODE: L40.52
<input type="checkbox"/> Moderate to Severe Plaque Psoriasis	ICD 10 CODE: L40.0
<input type="checkbox"/> Moderate to Severe Crohn's Disease	ICD 10 CODE: K50.90
<input type="checkbox"/> Other: _____	ICD 10 CODE: _____
<input type="checkbox"/> Moderate to Severe Rheumatoid Arthritis	ICD 10 CODE: M06.9
<input type="checkbox"/> Has the patient had failure or contraindication to at least 12 weeks of at least one Disease Modifying Antirheumatic Drug (DMARD)? <input type="checkbox"/> YES <input type="checkbox"/> NO	

REQUIRED DOCUMENTATION/TESTING	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Hepatitis B Test Results: HBsAg, Total HepB Core Antibody	<input type="checkbox"/> TB Test Results
List Tried & Failed Therapies, including duration of treatment:	
1)	
2)	

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Dosing	<input type="checkbox"/> Cimzia 400mg subcutaneous injection week 0, 2, and 4 followed by Cimzia 400mg subcutaneous injection every 4 weeks <input type="checkbox"/> Cimzia 400mg subcutaneous injection week 0, 2, and 4 followed by Cimzia 200mg subcutaneous injection every 2 weeks
Refills:	<input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> _____ doses
<ul style="list-style-type: none">New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.	

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:		Office Fax Number:	
Physician Signature:		Date:	

Contact us with questions at: Montgomery (334) 273-7000 or Prattville (334) 351-1000
Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207