



159 Fountains Blvd. Madison, MS 39110
Phone: 601.859.8200 Fax: 601.859.8201

**CIMZIA (CERTOLIZUMAB PEGOL)
SUB-Q ORDERS**

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis
- TB Test Attached Perform TB Testing
- TB Protocol:** Baseline testing: Quantiferon Gold (QFT Gold) or PPD. Yearly TB Screening (*Optional*)
- Hepatitis B Protocol:** Hep B surface antigen and Hep B Core AB total required.

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

- Crohn's Disease (ICD-10 Code: _____)
- Psoriatic Arthritis (ICD-10 Code: _____)
- Rheumatoid Arthritis (ICD-10 Code: _____)
- Ankylosing Spondylitis (ICD-10 Code: _____)
- Other _____ (_____)

J Code: J0717

CIMZIA ORDERS

Initial dose: 400mg SubQ at weeks 0, 2, and 4

Refills _____

Maintenance dose: 200mg SubQ every _____ weeks for _____ weeks
 400mg SubQ every _____ weeks for _____ weeks

Lab Order: _____

Additional Instructions:

Physician Name:	Phone:	Fax:
**Physician Signature:	Date:	