AYSA
THERAPEUTICS INFUSION CENTER

CIMZIA (CERTOLIZUMAB PEGOL) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Patient Weight: _____ lbs. Allergies: _____

J Code: J0717

Diagnosis:

☐ Crohn's Disease (ICD-10 Code: _____)

☐ Psoriatic Arthritis (ICD-10 Code: _____)

☐ Rheumatoid Arthritis (ICD-10 Code: _____)

☐ Ankylosing Spondylitis (ICD-10 Code: _____)

☐ Plaque Psoriasis (ICD-10 Code: _____)

☐ Non-radiographic Axial Spondyloarthritis (ICD-10 Code: _____)

☐ Other: _____

☐ **Required Labs:** TB (QFT or PPD), Hep B surface antigen and Hep B core AB total

☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis attached

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

CIMZIA ORDERS

Crohn's Disease

☐ Initial Dose: 400mg subcutaneously at weeks 0, 2, and 4 weeks

Maintenance Dose: ☐ 400mg subcutaneously every 4 weeks

RA/Psoriatic Arthritis/Ankylosing Spondylitis/Spondyloarthritis

☐ Initial Dose: 400mg subcutaneously at weeks 0, 2, and 4 weeks

Maintenance Dose: ☐ 200mg subcutaneously every 2 weeks

☐ 400mg subcutaneously every 4 weeks

Psoriasis

☐ 400mg subcutaneously every 2 weeks

☐ 200mg every 2 weeks

☐ 400mg subcutaneously at weeks 0, 2, and 4 followed by 200mg every 2 weeks

Additional Orders/Comments:

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc*. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____