Return Completed Form To:
888.898.9113

INFUSION ORDER – CIMZIA

Patient First Name: ___________________________ Patient Last Name: ___________________________

Address: ___________________________ City: ___________________________

State: ____________ Zip Code: ______________ Phone: ___________________________

Referral Date: ___________________________ Weight (kg): __________ Height (in): __________

Diagnosis: ____

Allergies: ___________________________________ TB Test Results: ______________

CIMZIA DOSING

- ☐ 400mg prefilled syringe
- ☐ 400mg lyophilized powder vial

FREQUENCY

- ☐ 400mg (given as two 200mg subcutaneous injections at week 0, 2 and 4
- ☐ Other ___________________________
- ☐ 400mg subcutaneous injection every 4 weeks
- ☐ Other___________________________

Prescribing Physician: ____

Address: ___________________________ City: ______________ State: _____ Zip: __________

Physician Phone: ______________________ Fax: ___________________________

Physician Signature: ___________________________ Date: ______________

ICD 10 CODE: ___________________________

To ensure payment by insurance carrier, please include with faxed order form supporting clinical documentation for specified ICD 10 Code, demographic and insurance information. Initial appointment will be verified upon insurance approval.