



# CIMZIA (CERTOLIZUMAB PEGOL) INJECTION ORDERS

**P:** 877.365.5566 | **F:** 855.889.2946

**PATIENT INFORMATION:** Fax completed form, insurance information, and clinical documentation to 855.889.2946

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_

**Patient Status:**  New to Therapy  Continuing Therapy **Next Treatment Date:** \_\_\_\_\_

**MEDICAL INFORMATION**

**Diagnosis:**  Crohn's Disease  Psoriatic Arthritis  Rheumatoid Arthritis  Plaque Psoriasis  
 Non-radiographic Axial Spondyloarthritis  Ankylosing Spondylitis  Other: \_\_\_\_\_

**ICD-10 Code:** \_\_\_\_\_

Patient Weight: \_\_\_\_\_ lbs. (required) Allergies: \_\_\_\_\_

**THERAPY ORDER**

**Crohn's Disease**

- Initial Dose: 400mg subQ at weeks 0, 2, and 4 weeks followed by 400mg subQ every 4 weeks x1 year
- 400mg subQ every 4 weeks x1 year

**RA/Psoriatic Arthritis/Ankylosing Spondylitis/Spondyloarthritis**

- Initial Dose: 400mg subQ at weeks 0, 2, and 4 weeks followed by *(select maintenance dosing below)*:
- 200mg subQ every 2 weeks x1 year
- 400mg subQ every 4 weeks x1 year

**Psoriasis**

- 400mg subQ every 2 weeks x1 year
- 400mg subQ at weeks 0, 2, and 4 followed by 200mg subQ every 2 weeks x1 year
- 200mg subQ every 2 weeks x1 year

**Lab Orders:** \_\_\_\_\_ **Lab Frequency:** \_\_\_\_\_

- Yearly TB testing QFT (optional)  Baseline HepBcAB total

Required labs to be drawn by:  Infusion Center  Referring Provider

Other orders: \_\_\_\_\_

**PROVIDER INFORMATION**

By signing this form and utilizing our services, you are authorizing Paragon Healthcare, Inc. and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

Provider Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Opt out of Paragon selecting site of care (if checked, please list site of care): \_\_\_\_\_

**PREFERRED LOCATION**

City: \_\_\_\_\_ State: \_\_\_\_\_

*View our locations here:*



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IMPORTANT NOTICE: This fax is intended to be delivered only to the named address and contains material that is confidential, privileged property, or exempt from disclosure under applicable law. If you are not the named addressee, you should not disseminate, distribute, or copy this fax. Please notify the sender immediately and destroy all copies if you have received this document in error.

**PATIENT INFORMATION:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL**

- Include signed and completed order (MD/prescriber to complete page 1)
- Include patient demographic information and insurance information
- Include patient's medication list
- Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy
  - Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, steroids, or conventional therapy (i.e., MTX, 6-MP, leflunomide)?  
 Yes  No If yes, which drug(s)? \_\_\_\_\_
  - Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Enbrel, Stelara)?  Yes  No  
If yes, which drug(s)? \_\_\_\_\_
  - If psoriasis diagnosis, percent of body surface (BSA) involved: \_\_\_\_\_ %
- Include labs and/or test results to support diagnosis
- If applicable* - Last known biological therapy: \_\_\_\_\_ and last date received: \_\_\_\_\_. If patient is switching to biologic therapies, please perform a wash-out period of \_\_\_\_\_ weeks prior to starting Cimzia.
- Other medical necessity: \_\_\_\_\_

**REQUIRED PRE-SCREENING**

- TB screening test completed within 12 months - attach results**
  - Positive**  **Negative**
  
- Hepatitis B screening test completed (Hepatitis B antigen) - attach results**
  - Positive**  **Negative**

\*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

Paragon Healthcare will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

**Please fax all information to (855) 889-2946 or call (877) 365-5566 for assistance**

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