PARAGON HEALTHCARE

A Carelon Company

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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COMPREHENSIVE SUPPORT FOR CIMZIA THERAPY

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 if a new start)- 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