IV INFUSION Treatment Center

FAX REFERRAL: **800-970-6020**

cimzia (certolizumab pegol)

Cimzia Referral Checklist

Date: ___/___/___.

Referring Physician: _____.

Physician's Telephone #: _____ Facsimile #: _____.

Patient's Name: _____ Date of Birth: ___/___/___.

- ☐ Patient Demographics
- ☐ Most Recent Office Visit Note
- ☐ Most recent Tb screening
- ☐ Diagnosis:
  - ☐ Crohn's Disease (K50-)
  - ☐ Rheumatoid Arthritis (M05.7-, M05.69, M05.89,M05.9, M06.09)
  - ☐ Other – Please Specify ICD 10 Diagnosis: _____

Dosing:

- ☐ **Initiation: Cimzia 400 mg SQ injection at weeks 0, 2, 4, and every 4 weeks thereafter**
- ☐ **Maintenance: Cimzia 400 mg SQ Injection every 4 weeks**

Comments:

Office Staff Name: _____ Signature _____.