



Patient Name: _____
Patient Phone: _____

DOB: _____
SEX: M F

Please Attach All Insurance Information, front and back

MEDICAL INFORMATION

Diagnosis: M06.9 Rheumatoid Arthritis
L40.52 Psoriatic Arthritis
M45.9 Ankylosing Spondylitis
L40.0 Plaque Psoriasis
Other: _____

Patients weight: _____
Lab Date: _____
Allergies: _____

ICD-10 _____

ALSO INCLUDE...

Clinical/ Progress Notes
Demographics Sheet
Current Medications
Labs

CIMZIA ORDER

Cimzia Dose:

Initial/Reload Dosing: _____ mg injection on day 0, 2 weeks, 4 weeks
then every _____ weeks.

Maintenance Dosing: _____ mg injection every _____ weeks.

Patients weight (kg): _____

Date of last Cimzia Infusions: _____

Additional Comments:

PHYSICIAN INFORMATION

Referring Physician: _____ Phone: _____

Practice Address: _____

Office Contact: _____ Fax: _____

NPI/ TIN: _____

Referring Physician's Signature _____ Date: _____