NORTH TEXAS INFUSION CENTERS

Cimzia® (certolizumab pegol) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
3.TB screening and Hepatitis B vaccine or testing documentation.

_____ _____
Patient Name **DOB**

_____ _____
Allergies **Patient Phone**

Diagnosis (must include ICD10 code)
☐ Rheumatoid Arthritis _____ ☐ Psoriatic Arthritis_____
☐ Ankylosing Spondylitis_____ ☐ Crohn's Disease_____
☐ Other (ICD-10 Code):_____

Prescription Orders: Cimzia® (certolizumab pegol) 200mg lyophilized powder

☐ **Initial Dosing**: 400mg (divided into two doses) Sub-Q at weeks 0, 2 and 4

☐ **Maintenance Dosing**: ☐ 200 mg Sub-Q every 2 weeks
☐ 400 mg (divided into two doses) Sub-Q every 4 weeks

☐ **Refills:** ☐ **12 months** ☐ **_____injections**

_____
Physician Name **Phone** **Fax**

_____
Physician's signature **Date**

Fax completed form to (214) 887-0436.Contact us directly at: (214) 276-5642.
Or visit us online at www.ntinfusioncenters.com

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