Phone: (865) 862 - 4557
www.heartlandinfusion.com
Fax: (865) 862 – 4556
Alt. Fax: (865) 867 - 7081

Cimzia Order Form

Please fax completed form with patient demographic information, front and back of insurance card (s), recent lab results, and recent office visit notes supporting diagnosis to (865) 862-4556.

Referral Status: ☐ New referral ☐ Dose or frequency change ☐ Order Renewal

PATIENT INFORMATION

Name:

Home Phone: Cell Phone:

Email: Last four Social Security number

DOB: Height: Weight:

Allergies:

ICD-10 Diagnosis Code: Years with Disease:

TB Test (Circle One): Skin Quantiferon Chest Xray Result: Date:

LABORATORY ORDERS

☐ CBC w/ Diff	☐ each infusion	☐ Other	______
☐ CRP	☐ each infusion	☐ Other	______
☐ CMP	☐ each infusion	☐ Other	______
☐ ESR	☐ each infusion	☐ Other	______
☐ Hepatic Panel	☐ each infusion	☐ Other	______
☐ Renal Panel	☐ each infusion	☐ Other	______
☐ Quantiferon TB (annually)		Due:	______
☐ Other			

Therapy Orders

☐ Induction: Administer Cimzia (certolizumab) 400mg/mL SQ at weeks 0, 2 and 4, then __________ mg every ________ weeks.

☐ Maintenance: Administer Cimzia (certolizumab) ☐ 200mg SQ every two weeks **OR** ☐ 400mg SQ every four weeks **OR** (specify):

____

☐ Nursing per Heartland Nursing Procedures (incl reaction management)

☐ Pre-Medications ☐ No routine pre-medications required

☐ Tylenol (acetaminophen) ________ mg PO ☐ Zyrtec (cetirizine) 10 mg PO

☐ Solu-Medrol (methylprednisolone) ________mg IV ☐ Claritin (loratadine) 10 mg PO

☐ Benadryl (diphenhydramine) ________mg ☐ PO ☐ IV

☐ Other: ____

PHYSICIAN INFORMATION

Physician's Name:

License #: NPI#: DEA#:

Address:

City: State: Zip:

Office Contact: Email:

Office Phone: Office Fax:

Physician Signature: ______________________________________ Date: ____________

Patient is being referred to: ☐ Knoxville ☐ Morristown ☐ Kingsport