HEARTLAND INFUSION

Fax to Heartland (1.865.862.4556)
Questions? Call (1.865.862.4557)

Cimzia Order Form

Please fax completed form with patient demographics, front and back of insurance card(s), recent lab results, and recent office visit notes supporting diagnosis to 865.862.4556.

Type of Referral: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Location: ☐ Jackson ☐ Knoxville ☐ Morristown ☐ Kingsport

PATIENT INFORMATION

First Name: _____ Last Name: _____ DOB: _____ Gender: (**check one**) ☐ M ☐ F

Home Phone: _____ Mobile Phone: _____

Email: _____ Last 4 of SS#: _____

Allergies: _____ Height: _____ Weight: _____

ICD-10 Diagnosis Code(s): _____ Date of Diagnosis: _____

TB Test (**circle one**): Skin Quantiferon Chest X-ray Result: _____ Date: _____

THERAPY ORDERS

☐ Induction: Administer Cimzia (certolizumab) 400mg/ml SubQ at weeks 0, 2, and 4 then _____mg every _____ weeks

☐ Maintenance: Administer Cimzia (certolizumab) ☐ 200mg SubQ every 4 weeks **OR** ☐ 400mg SubQ every 4 weeks **OR** (specify): _____

☐ Nursing per Heartland Nursing Procedures (including reaction management)

Pre Medications

☐ **No routine pre-medications required**

☐ Tylenol (acetaminophen) _____mg PO

☐ Zyrtec (cetirizine) 10mg PO

☐ Solu-Medrol (methylprednisolone) IV ☐ 40 mg, ☐ 125 mg, ☐ other _____mg

☐ Claritin (loratadine) 10mg PO

☐ Benadryl (diphenhydramine) _____mg ☐ PO ☐ IV

☐ Other: _____

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: _____

PRESCRIBER'S INFORMATION

Prescriber Name: _____

License #: _____ NPI: _____ DEA: _____

Address: _____

City: _____ State: _____ Zip: _____

Office Contact: _____

Office Phone: _____ Office Fax: _____

Prescriber's Signature: _____