



Cimzia Order Form

Select patient referral location: Blue Ash Worthington Crestview Hills Springfield West Cincinnati
Fax completed form to 888-977-0914. For new referrals, please include recent labs and last two office visit notes.

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:	NPI#:	
License #: <input type="checkbox"/> TIN#:	DEA#:	
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

Rheumatoid Arthritis (_____) Ankylosing Spondylitis (_____) ICD 10 (_____)
 Psoriatic Arthritis (_____) Crohn's Disease (_____) Other (specify): _____

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

CIMZIA Initial Maintenance

Administer single 200mg/mL injection every two weeks **OR**
 Administer 2 X 200mg/mL injection every four weeks **OR**
 Administer _____

Loading Dose: Administer two 200mg injections at weeks 0, 2 and 4, then _____ mg every _____ weeks

Vital signs per HI Protocol
 Anaphylaxis & Hydration Management per HI Protocol

PRE-MEDICATIONS N/A

Acetaminophen 500mg 650mg 1000mg PO
 Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
 Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)
 Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV
 Prednisone _____ mg PO
 Other: _____

POST-MEDICATIONS N/A

Acetaminophen 500mg 650mg 1000mg PO
 Prednisone _____ mg PO
 Other: _____

6. LABS

CBC w/Diff each infusion Other frequency (specify): _____
 CRP each infusion Other frequency (specify): _____
 CMP each infusion Other frequency (specify): _____
 ESR each infusion Other frequency (specify): _____
 Hepatic Panel each infusion Other frequency (specify): _____
 Renal Panel each infusion Other frequency (specify): _____
 Quantiferon TB Gold, annually, last completed (date): _____
 Other (specify): _____

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE