

## **Cimzia Order Form**

**PHYSICIAN'S SIGNATURE** 

## **Select referral location:**

Akron Columbus (East Broad)

Athens Columbus (Hilliard)

Cincinnati (Blue Ash) Columbus (Worthington) Mansfield
Cincinnati (West) Dayton (Beavercreek) Perrysburg
Cleveland Dayton (Englewood) Springfield

Crestview Hills (NKY)

Toledo

Findlay

Liberty

## For new referrals, please include recent labs and last two office visit notes.

			form to 888-977  www.horizoning		C	imzia 0	rder Form
1. PATIENT INFORMATIO							
Name:			DOB:				
Phone:			Other Phone:				
Email:							
Social Security #:			Allergies:				
Gender: M F			Weight:	Lb	s Kọ	]	
	therapy Continuing	therapy	Next due date (if	applicable):			
2. INSURANCE INFORM	MATION ( <i>required)</i> of the front and back of pri	mary and/or o	secondary insuranc	e carde with thi	ic referra		
		illary allu/or s	secondary msurant	e carus with thi	is referra		
3. PHYSICIAN INFORMA	ATION						
Physician Name:			NPI#:				
License #:	TIN#:		DEA#:				
Address:							
City:			State		Zip		
Office Contact:			Email:				
Office phone:			Office fax:				
4. DIAGNOSIS INFORMA	ATION (and vear of diag	ınosis)					
Rheumatoid Arthritis (		g Spondyliti:	s ( )	ICD 10		*Hep B and	TB required prior
Psoriatic Arthritis (	5			Other:		to initial inf	
5. PRESCRIPTION INFO	RMATION (requires new	v order ever	y 12-months)				
CIMZIA			PRE-MEDICATIO	NS N/A			
						100	nma
Initial Mainten	nance		Acetaminophen	500mg	650mg	100	villy
		aeke NP	Fexofenadine (All	egra) 180mg P	_	•	ting antihistamine)
Administer single 200mg	/mL injection every two we	eeks OR	Fexofenadine (All Diphenhydrimine	egra) 180mg P (Benadryl)	0 (or oth 25mg	•	•
Administer single 200mg		eeks OR s OR	Fexofenadine (All Diphenhydrimine ( Methylprednisolo	egra) 180mg P (Benadryl) ne (Solu-Medr	O (or oth	er non-seda 50mg	ting antihistamine)
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**DATE**