



Patient Name: \_\_\_\_\_  
Patient Phone: \_\_\_\_\_

DOB: \_\_\_\_\_  
SEX: M F

Please Attach All Insurance Information, front and back

### MEDICAL INFORMATION

**Diagnosis:** M06.9 Rheumatoid Arthritis  
L40.52 Psoriatic Arthritis  
M45.9 Ankylosing Spondylitis  
L40.0 Plaque Psoriasis  
Other: \_\_\_\_\_  
ICD-10 \_\_\_\_\_

#### ALSO INCLUDE...

- Clinical/ Progress Notes
- Insurance Cards
- Demographics Sheet
- Current Medications
- Labs

### CIMZIA ORDER

**Cimzia Dose:**

Initial/Reload Dosing: \_\_\_\_\_ mg injection on day 0, 2 weeks, 4 weeks then every \_\_\_\_\_ weeks.

Maintenance Dosing: \_\_\_\_\_ mg injection every \_\_\_\_\_ weeks.

Patients weight (kg): \_\_\_\_\_

Date of last Cimzia Infusions: \_\_\_\_\_

**Additional Comments:**

### PHYSICIAN INFORMATION

Referring Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Practice Address: \_\_\_\_\_

Office Contact: \_\_\_\_\_ Fax: \_\_\_\_\_

NPI/ TIN: \_\_\_\_\_

Referring Physician's Signature \_\_\_\_\_ Date: \_\_\_\_\_