Cimzia Injection Order

INFUSION FOR HEALTH

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ____ / ____ / ____ Treatment Location: _____

***Please fax a copy of the following patient information:**

☐ Demographics ☐ Insurance Information ☐ Current Medications
☐ H & P Relevant to Diagnosis ☐ Current Lab Results (including TB & Hep B)

PATIENT INFORMATION

Patient Name: _____

DOB: ____ / ____ / ____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: ____ / ____ / ____

Phone: (____) ____ - ____ Fax: (____) ____ - ____

Office Address: _____

Contact Person: _____

CIMZIA DOSAGE

400 mg subcutaneous (2 x 200 mg/mL)

Frequency: Administer at week 0, 2, 4

and **then** _____mg every _____weeks.