March 2024

LOWCOUNTRY
**Rheumatology**
A Member of Articularis Healthcare Group,Inc.

Please fax completed form, insurance card, and clinical documentation to:
**FAX: (843) 793-6181**

## CIMZIA ORDER

☐ **New Start** ☐ **Maintenance: Last Dose Given**_____

| Referring Office: | Contact Name: | Date: |
|---|---|---|
| Direct Phone for Contact: | Fax: | |
| Patient Name: | DOB: | |

Allergies ☐ NKDA ☐ Allergies: _____

Height: _____ Weight: _____

**Indication:**

☐ M05.79 RA with rheumatoid factor of multiple sites w/o organ involvement
☐ L40.5__ Psoriatic arthropathy
☐ Other _____
☐ M06.09 RA w/o rheumatoid factor, multiple sites
☐ M45.9 Ankylosing spondylitis, unspecified site in spine
☐ M45.A6 Non-radiographic axial spondylarthritis of lumbar region

**DOSE:**

☐ With Loading Doses: 400mg SQ at weeks 0, 2 and 4 then every 4 weeks
☐ With Loading Doses: 400mg SQ at weeks 0, 2 and 4 then 200mg every 2 weeks
☐ Maintenance Only: 400mg every 4 weeks
☐ Maintenance Only: 200mg every 2 weeks
☐ _____

| Prescriber Name: | Title: |
|---|---|
| NPI: | DEA: |
| Prescriber Signature: | Date of Order: |

**Referrals will not be processed until we receive <u>ALL</u> the following:**

☐ Face Sheet / Patient Demographics
☐ Insurance card(s) – copy of front & back
☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes)
Most Recent Labs (within last 4-8 weeks) – Required:
☐ CBC ☐ CMP ☐ TB ☐ Hep B Other: _____