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 ALL 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 ☐ Lipids ☐ TB ☐ Hep B Other: ____