

Checklist for Cimzia Lyo (certolizumab pegol) Referral

Required documentation for all initial referrals

Patient _____ DOB _____ Date _____ New Start Maintenance

Please return **completed** checklist and checklist items for an infusion referral:

- Patient demographics (e.g. address, phone number, SSN, etc.)
- Insurance information and copy of insurance card(s). Please indicate the insurance that is primary, and the insurance that is secondary, if applicable, and the subscriber’s date of birth.
 - If insurance requires prior authorization, please provide the phone number and allow up to 15-30 days for this to be completed by one of our Infusion Coordinators.
- Signed and completed Cimzia Standard Order (our order form) with ICD diagnosis code
 - *Standard Order forms are available at lowcountryrheumatology.com/infusions/*
- Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy, and how long patient has been on Cimzia Lyo.
- Lab results and/or tests to support diagnosis.
 - Pre-Screening:
 - **Required TB screening results:** PPD (*within 1 year*) or QuantiFERON Gold Test (*within 3 years*)
 - **Required Hepatitis screening (*within 1 year*):** Hepatitis B Surface Antigen, Hepatitis B Surface Antibody, or Hepatitis B Core Antibody results and Hepatitis C Antibody results
 - **Lab results within last 30 days:** CBC
 - **Most recent Rapid 3 (if available)**
- Please indicate name and direct phone number of a contact within your office that we can speak with to obtain any additional information:
 - Name: _____
 - Phone Number: _____

Paperwork can be faxed to (843)-793-6181

Infusion Coordinators can assist you with any questions at
(843)-572-8932

Low Country Rheumatology Infusion Locations

Please mark preferred location and we will do our best to accommodate, however we cannot make any guarantees.

Summerville

2001 2nd Ave, Suite 201, Summerville, SC 29486

Mount Pleasant

1100 Johnnie Dodds Blvd, Mt. Pleasant, SC 29464

West Ashley

2291 Henry Tecklenburg Drive, Charleston, SC 29414

Low Country Rheumatology Infusion Services will complete insurance verification and submit all required clinical documentation to the patient’s insurance company for eligibility. Our Infusion Coordinators will notify you if any further information is required. The patient will have an annual 30-minute consult with our NP to obtain H&P for chart. We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Thank you for the referral!

Low Country Rheumatology Use Only Existing Patient Yes _____ No _____ Physician _____

Standard Orders for Cimzia Lyo (certolizumab pegol) Administration

Patient _____ DOB _____ Date _____

***NOTE:** Patient is ineligible to receive Cimzia if they have suspected infectious process or is receiving antibiotic for active infectious process due to the possibility of developing a super infection related to its effect on the immune system.

Indication:

<input type="checkbox"/> M05.79 RA with rheumatoid factor of multiple sites w/o organ involvement	<input type="checkbox"/> M06.09 RA w/o rheumatoid factor, multiple sites	<input type="checkbox"/> L40.50 Arthropathic psoriasis
<input type="checkbox"/> L40.59 Other psoriatic arthropathy	<input type="checkbox"/> M45.9 Ankylosing spondylitis, unspecified site in spine	<input type="checkbox"/> Crohn's disease, please specify: _____
<input type="checkbox"/> L40.0 Plaque Psoriasis		

History:

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Inadequate response to DMARD _____ <input type="checkbox"/> Rapid 3 _____ <input type="checkbox"/> ESR/CRP _____ <input type="checkbox"/> HBsAg, HBsAb, HB core Ab, HCAb _____ <input type="checkbox"/> History of skin cancer _____ | <ul style="list-style-type: none"> <input type="checkbox"/> Unable to tolerate DMARD _____ <input type="checkbox"/> Swollen/tender joints _____ <input type="checkbox"/> Progressive erosive arthropathy _____ <input type="checkbox"/> Recent or upcoming surgery _____ |
|---|--|

Dose:

- Loading dose Cimzia 400mg SQ at weeks 0, 2, and 4 then every 4 weeks
- Loading dose Cimzia 400mg SQ at weeks 0, 2, and 4 then Cimzia 200mg SQ every 2 weeks

Additional orders/comments:

Practice Name: _____

NPI: _____

Physician Name: _____

State License: _____

Physician Signature: _____

DEA #: _____

Date: _____

UPIN: _____