MIC | METRO INFUSION CENTER

INFUSION ORDERS-CIMZIA (CERTOLIZUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Active Ankylosing Spondylitis	ICD 10 Code: M45.9
☐ Active Axial Spondyloarthritis	ICD 10 Code: M47.9
☐ Active Psoriatic Arthritis	ICD 10 CODE: L40.52
☐ Moderate to Severe Plaque Psoriasis	ICD 10 CODE: L40.0
☐ Moderate to Severe Crohn's Disease	ICD 10 CODE: K50.90
☐ Other: _____	ICD 10 CODE: _____
☐ Moderate to Severe Rheumatoid Arthritis	ICD 10 CODE: M06.9
Has the patient had failure or contraindication to at least 12 weeks of at least one DMARD? ☐ YES ☐ NO	

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progress notes
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody	☐ TB Test Results
List Tried & Failed Therapies, including duration of treatment: 1) 2)	

MEDICATION ORDERS	
Dosing	Please indicate frequency in blank space provided. ☐ Cimzia 200mg SubQ _____ ☐ Cimizia 400mg SubQ _____ ☐ Other: Cimzia _____ mg SubQ _____
Refills:	☐ X 6 months ☐ X 1 year ☐ _____ doses

PRESCIBER INFORMATION		
Prescriber Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date:

Contact us with questions at: BioNurses@MetroInfusionCenter.com or call (877) 448-3627

Fax completed form and all documentation to (866) 507-1164

All information contained in this form is strictly confidential and will become part of the patient's medical record.