



Cimzia Order Form

Select patient referral location: **Akron** **Athens** **Blue Ash** **Cleveland** **Columbus** **Crestview Hills**
Dayton **Mansfield** **Perrysburg** **Springfield** **Toledo** **West Cincinnati**

Fax completed form to 888-977-0914. For new referrals, please **include recent labs and last two office visit notes.**

Toll Free Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

2. PHYSICIAN INFORMATION

Physician's name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

3. DIAGNOSIS INFORMATION (and year of diagnosis)

<input type="checkbox"/> Rheumatoid Arthritis (_____)	<input type="checkbox"/> Ankylosing Spondylitis (_____)	<input type="checkbox"/> ICD 10 (_____)
<input type="checkbox"/> Psoriatic Arthritis (_____)	<input type="checkbox"/> Crohn's Disease (_____)	<input type="checkbox"/> Other (specify): _____

4. INSURANCE INFORMATION

Please submit copies of the front and back or primary and secondary insurance cards with this referral.

5. PRESCRIPTION INFORMATION (requires new order every 12 months)

CIMZIA <input type="checkbox"/> Initial <input type="checkbox"/> Maintenance	PRE-MEDICATIONS <input type="checkbox"/> N/A
<input type="checkbox"/> Administer single 200mg/mL injection every two weeks OR	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
<input type="checkbox"/> Administer 2 X 200mg/mL injection every four weeks OR	<input type="checkbox"/> Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
<input type="checkbox"/> Administer _____	<input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> PO <input type="checkbox"/> IV (requires driver)
<input type="checkbox"/> Loading Dose: Administer two 200mg injections at weeks 0, 2 and 4, then _____ mg every _____ weeks	<input type="checkbox"/> Methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg <input type="checkbox"/> 80mg <input type="checkbox"/> 125mg IV
<input type="checkbox"/> Vital signs per HI Protocol	<input type="checkbox"/> Prednisone _____ mg PO
<input type="checkbox"/> Anaphylaxis & Hydration Management per HI Protocol	<input type="checkbox"/> Other: _____
	POST-MEDICATIONS <input type="checkbox"/> N/A
	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
	<input type="checkbox"/> Prednisone _____ mg PO
	<input type="checkbox"/> Other: _____

6. LABS

<input type="checkbox"/> CBC w/Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): _____		
<input type="checkbox"/> Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE