Cimzia Enrollment Form

Date: _____
Patient Name: _____
Date of Birth: _____

TwelveStone Health Partners
Fax Referral To:
(800) 223-4063
Direct Phone: (615) 278-3350
Toll Free: (844) 893-0012

PREVIOUS ADMINISTRATION

If YES, please provide the following information:	If NO, please indicate desired location for first dose:
Last Injection Date: _____ Next Injection Date: _____	☐ Physician's Office TwelveStone Infusion Center: ☐Canton ☐Chattanooga ☐Knoxville ☐Mount Juliet ☐Murfreesboro ☐ Other: _____ Desired Start Date: _____

DIAGNOSIS

Description	*ICD-10 Code*
☐ RA ☐ Crohn's ☐Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐Plaque Psoriasis ☐ Other	☐ M06.9 ☐ K50.0 ☐ L40.5 ☐ M45 ☐ L40 ☐ Other:_____

OTHER REQUIRED DOCUMENTATION *(Please attach documents as needed)*

☐ This signed order form	☐ History and Physical
☐ Patient Demographics and Insurance Information	☐ Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

CLINICAL INFORMATION *(Please attach all clinical information, lab results and other medical history documents)*

Patient Weight: :_____ Kg/Lbs Height:_____Inches/CM BSA :_____ Allergies: _____

MEDICATION	DOSE	DIRECTIONS	REFILLS	BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)
☐ Cimzia	☐ 200mg/ml Vial (will be used unless training for home Administration)	☐ Initiation - Inject 400mg (2ml - 2 syringes) SQ at weeks 0, 2, and 4.		☐ CBC w/Differential ☐ Tb QuantiFERON Gold ☐ HBV Testing
	☐ 200mg/ml PFS	☐ Maintenance - Inject _____ mg SQ every _____ week.s		

LAB ORDERS - To be drawn by TwelveStone

Order	Frequency
CBC w/Differential	☐One Time Prior to Treatment ☐Every Treatment ☐Q ____Weeks ☐Other_____
CBC w/o Differential	☐One Time Prior to Treatment ☐Every Treatment ☐Q ____Weeks ☐Other_____
CMP	☐One Time Prior to Treatment ☐Every Treatment ☐Q ____Weeks ☐Other_____
BMP	☐One Time Prior to Treatment ☐Every Treatment ☐Q ____Weeks ☐Other_____
CRP	☐One Time Prior to Treatment ☐Every Treatment ☐Q ____Weeks ☐Other_____
Sed Rate	☐One Time Prior to Treatment ☐Every Treatment ☐Q ____Weeks ☐Other_____
Calcium	☐One Time Prior to Treatment ☐Every Treatment ☐Q ____Weeks ☐Other_____
Tb QuantiFERON Gold	☐One Time Prior to Treatment ☐Every Treatment ☐Q ____Weeks ☐Other_____
Hepatitis Panel	☐One Time Prior to Treatment ☐Every Treatment ☐Q ____Weeks ☐Other_____
Other_____	☐One Time Prior to Treatment ☐Every Treatment ☐Q ____Weeks ☐Other_____

PRE-MEDICATIONS

Oral	IV
Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg	Dexamethasone: ☐ 4mg ☐ 8mg
Cetirizine: ☐ 10mg	Diphenhydramine: ☐ 25mg ☐ 50mg
Diphenhydramine: ☐ 25mg ☐ 50mg	Famotidine: ☐ 20mg ☐ 40mg
Famotidine: ☐ 20mg ☐ 40mg	Methylprednisolone: ☐ _____mg IV over _____ mins
Ibuprofen: ☐ 200mg	Ondansetron: ☐ 4mg ☐ 8mg
Loratidine: ☐ 10mg	
Ondansetron: ☐ 4mg	

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

Physician's Phone #	Physician's NPI#	Physician's Fax #	Physician's Address
Dispense as Written	Date	Substitution Allowed	Date