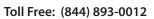
## **TwelveStone Health Partners**

Fax Referral To: (800) 223-4063

Email: intake@12stonehealth.com

Direct Phone: (615) 278-3350





CIMZIA ORDER FORM						
Date:		ICD-10 Code:		Therapy Status		
Patient Name:		Allergies:		☐ New Start		
Date of Birth:		Weight:lbs ORkg		☐ Continuing Therapy:  Last Dose:		
PROVIDER INFORMATION						
Ordering		_ Provider Fax:	Provider Fax:			
Provider NPI:			_ Provider Address:	Provider Address:		
Provider Phone:						
MEDICATION ORDER						
Cimzia  Loading Dose: Cimzia 400mg SQ at weeks 0, 2 and 4.  Maintenance Dose: Cimzia mg SQ every weeks.		Refills x one year from date of signature unless indicated below.   Refills		Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:   TB Quant Gold within the past 12 months  Hepatitis B Surface Antigen		
PRE-MEDICATIONS						
Oral         □ Acetaminophen:325mg500mg650mg         □ Loratadine: 10mg         □ Cetirizine: 10mg         □ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Ibuprofen:200mg400mg600mg         □ Ondansetron:4mg8mg         □ Other:			□ Diphenhy □ Famotidir □ Methylpre □ Hydrocort □ Ondanset	□ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg □ Ondansetron:4mg8mg		
LAB ORD	to be drawn and frequency	)				
**Surveillance lab ordering and monitoring is the responsibility of the prescriber**			to 800-223-406  • History & Phy  • Patient Demo  • Medication Li	(Please fax this signed order form, along with the following documents to 800-223-4063)  • History & Physical, Last Office Visit Note  • Patient Demographics and Insurance Information  • Medication List  • Recent Lab Work		
•	e above therapy is medic			er's Signature (SIGN BELOW)		
Dispense as Written:			Substitution All			
Prescriber Name Date		Prescriber Nam	Prescriber Name Date			

V 9.26.23