O·S·M·S
ORTHOPEDIC & SPORTS MEDICINE SPECIALISTS

RHEUMATOLOGY & INFUSION THERAPY CLINIC
Green Bay • Fox Valley • Marinette • Oshkosh
Phone: 920-430-8113 • Infusion Fax: 920-965-6389
osmsgb.com

Cimzia (Certolizumab) Injection

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal
Infusion Office Preference: ☐ Green Bay ☐ Neenah ☐ Marinette

PATIENT INFORMATION		
Date:	Patient Name:	DOB:
☐ NKDA Allergies:		Weight:
Patient Status: ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date:		Next Due Date:

PROVIDER INFORMATION			
Office Contact Name:	Office Email:		
Prescribing Providers Name:	Provider NPI:		
Office Address:	City:	State:	Zip:
Office Phone Number:	Office Fax Number:		

DIAGNOSIS AND ICD 10 CODE		REQUIRED DOCUMENTATION
☐ Active Ankylosing Spondylitis	ICD 10 Code: M45.9	☐ This signed order form by the provider
☐ Active Axial Spondyloarthritis	ICD 10 Code: M47.9	☐ Patient demographics AND insurance information (copy of cards)
☐ Active Psoriatic Arthritis	ICD 10 Code: L40.52	☐ Clinical/Progress notes
☐ Moderate to Severe Plaque Psoriasis	ICD 10 Code: L40.0	☐ Lab and Tests supporting primary diagnosis
☐ Moderate to Severe Crohn's Disease	ICD 10 Code: K50.90	☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody
☐ Moderate to Severe Rheumatoid Arthritis	ICD 10 Code: M06.9	☐ Hepatitis C Test Results
☐ Other: _____	ICD 10 Code: _____	☐ TB Test Results

Has the patient had failure or contraindication to at least 12 weeks of at least one DMARD? ☐ Yes ☐ No

List Tried & Failed Therapies, including duration of treatment:

1.
2.
3.

MEDICATION ORDERS (order will expire in 1 year unless otherwise specified)	
Dosing	☐ Cimzia 200mg SubQ every 2 weeks ☐ Cimzia 400mg SubQ every 4 weeks ☐ Other: Cimzia _____mg SubQ _____
Refills	☐ X6 months ☐ X1 year ☐ _____ doses

Provider Name (Print) **Provider Signature:** **Date:**

Fax Referral to 920-965-6389

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