LAWRENCE COUNTY
Memorial Hospital
DEACONESS ILLINOIS PARTNER

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

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

DIAGNOSIS AND ICDE 10 CODE

☐ Ankylosing Spondylitis	ICD 10 Code: M45.9
☐ Non-radiographic axial spondyloarthritis	ICD 10 Code: M45.A0
☐ Psoriatic Arthritis	ICD 10 Code: L40.50
☐ Moderate to Severe Plaque Psoriasis	ICD 10 Code: L40.0
☐ Moderate to Severe Crohn's disease	ICD 10 Code: K50.90
☐ Moderate to Severe Rheumatoid Arthritis	ICD 10 Code: M06.9
☐ Other: _____	ICD 10 Code: _____

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

REQUIRED DOCUMENTATION (referral will not be processed without the required documentation)

☐ The signed order form by the provider	☐ Clinical/Progress notes (must be within 1 year)
☐ Patient demographics AND insurance information	☐ Labs and Tests supporting primary diagnosis
☐ Prior authorization with reference number	☐ Hepatitis B Test Results: HBsAg, Total HepB Core
*Pt may be required to submit a pregnancy test prior to treatment	☐ TB test results

List tried and failed therapies including duration of treatment:

1) _____
2) _____

MEDICATION ORDERS

Dosing Wt for Calculation: HT: _____ WT (kg): _____ BMI: _____ Pt WT required for weight-based orders

Dosing	☐ J0717 Cimzia 400mg SubQ injection at week 0, 2, and 4 and every 4 weeks thereafter ☐ J0717 Cimzia 400mg SubQ injection at week 0, 2, and 4 and then 200mg SubQ injection every other week thereafter ☐ Other: _____

Duration: ☐ x6 months ☐ x 1 year ☐ x _____ doses

ADDITIONAL ORDERS/ INFORMAITON

PRESCRIBER INFORMATION

Provider Name:		
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:		Date: Time:

ALL INFORMATION COUNTAINED IN THIS ORDER FORM IS STRICTLY CONFIDENTIAL AND WILL BECOME PART OF THE PATIENTS MEDICAL RECORD.

CONTACT US WITH QUESTIONS AT 618-943-8515
FAX COMPLETED FORM AND ALL DOCUMENTS TO 618-943-7242

INFUSION ORDERS –CIMZIA (CERTOLIZUMAB)