Updated September 17, 2019

Checklist for Cimzia Lyo (certolizumab pegol) Referral

Required documentation for all initial referrals

Patient _____DOB_____ Date_____ □ New Start □ Maintenance

Please return **completed** checklist and checklist items for an infusion referral:

- ☐ Patient demographics (e.g. address, phone number, SSN, etc.)
- ☐ Insurance information and copy of insurance card(s). Please indicate the insurance that is primary, and the insurance that is secondary, if applicable, and the subscriber's date of birth.
  - If insurance requires prior authorization, please provide the phone number and allow up to 15-30 days for this to be completed by one of our Infusion Coordinators.
- ☐ Signed and completed Cimzia Standard Order (our order form) with ICD diagnosis code
  - *Standard Order forms are available at lowcountryrheumatology.com/infusions/*
- ☐ Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy, and how long patient has been on Cimzia Lyo.
- ☐ Lab results and/or tests to support diagnosis.
  - Pre-Screening:
    - **Required TB screening results**: PPD *(within 1 year)* or QuantiFERON Gold Test *(within 3 years)*
    - **Required Hepatitis screening *(within 1 year)***: Hepatitis B Surface Antigen, Hepatitis B Surface Antibody, or Hepatitis B Core Antibody results and Hepatitis C Antibody results
    - **Lab results within last 60 days:** ESR/CRP results
    - **Most recent Rapid 3 (if available)**
- ☐ Please indicate name and direct phone number of a contact within your office that we can speak with to obtain any additional information:
  - Name: _____
  - Phone Number: _____

Paperwork can be faxed or emailed to (404) 528-1852, argpriorauth@articularishealthcare.com

Arthritis & Rheumatology of GA
Prior Authorization Department will assist you with any questions at
(404) 255-5956 extension:910

Arthritis & Rheumatology of GA services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our Prior Authorization Department will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available co-pay assistance as required. Thank you for the referral!

Arthritis & Rheumatology of GA Use Only Existing Patient Yes____ No____ Physician _____

Updated September 17, 2019

Standard Orders for Cimzia Lyo (certolizumab pegol) Administration

Patient _____DOB_____ Date_____

***NOTE**: Patient is ineligible to receive Cimzia if they have suspected infectious process or is receiving antibiotic for active infectious process due to the possibility of developing a super infection related to its effect on the immune system.

Indication:

☐ M05.79 RA with rheumatoid factor of multiple sites w/o organ involvement	☐ M06.09 RA w/o rheumatoid factor, multiple sites	☐ L40.50 Arthropathic psoriasis
☐ L40.59 Other psoriatic arthropathy	☐ M45.9 Ankylosing spondylitis, unspecified site in spine	☐ Crohn's disease, please specify: _____
☐ L40.0 Plaque Psoriasis		

History:

☐ Inadequate response to DMARD _____

☐ Rapid 3_____

☐ ESR/CRP

☐ HBsAg, HBsAb, HB core Ab, HCAb

☐ History of skin cancer

☐ Unable to tolerate DMARDS

☐ Swollen/tender joints

☐ Progressive erosive arthropathy

☐ Recent or upcoming surgery

Dose:

☐ Loading dose Cimzia 400mg SQ at weeks 0, 2, and 4 then every 4 weeks

☐ Loading dose Cimzia 400mg SQ at weeks 0, 2, and 4 then Cimzia 200mg SQ every 2 weeks

Additional orders/comments:

_____

_____

Practice Name: _____

Physician Name: _____

Physician Signature: _____

Date: _____

NPI: _____

State License: _____

DEA #: _____

UPIN: _____