

Patient Referral and CIMZIA® Prescription Form

Complete and fax to 1-866-949-2469

Please choose one: Benefit verification Direct to pharmacy



PATIENT INFORMATION <i>Please provide physical address; no P.O. boxes.</i>		PRACTITIONER INFORMATION			
Patient name (last, first)		Practitioner name (last, first)			
DOB	SSN#	Gender: M <input type="checkbox"/> F <input type="checkbox"/>	DEA#	Tax ID#	State Lic# NPI#
Physical address		Specialty		CIMplicity ID	
City/State/ZIP		Address			
Home phone	Work phone		City/State/ZIP		
Cell phone			Contact	Phone	
E-mail			E-mail	Fax	

INSURANCE INFORMATION <i>Please fax a copy of the front AND back of insurance card(s).</i>	
Primary insurance	Pharmacy benefit or secondary insurance
Primary insurance phone	Insurance phone
Policyholder name	Policyholder name
DOB	SSN#
Policy#	Group#
	Policy#
	Group/BIN#

MEDICAL INFORMATION			
Prior history: <input type="checkbox"/> 5-ASA <input type="checkbox"/> Immunosuppressants (6-MP or other) <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Methotrexate <input type="checkbox"/> Surgery <input type="checkbox"/> Other _____	Prior biologic use: <input type="checkbox"/> Remicade® <input type="checkbox"/> Enbrel® <input type="checkbox"/> Humira® <input type="checkbox"/> Orencia® <input type="checkbox"/> Simponi™ <input type="checkbox"/> Rituxan® <input type="checkbox"/> Actemra® <input type="checkbox"/> CIMZIA®	Date of last dose: _____ _____ _____ _____ _____ _____	Primary diagnosis (ICD-9-CM): CD: <input type="checkbox"/> 555.0 <input type="checkbox"/> 555.1 <input type="checkbox"/> 555.2 <input type="checkbox"/> 555.9 RA: <input type="checkbox"/> 714.0 <input type="checkbox"/> 714.2 <input type="checkbox"/> Other _____ Date of diagnosis: _____ Drug allergies: _____ <input type="checkbox"/> NKDA Date of last TB test: _____ Date to start CIMZIA: _____ Deliver to: <input type="checkbox"/> Patient's home <input type="checkbox"/> Physician's office

CIMZIA® (certolizumab pegol) PREFILLED SYRINGE (PFS)	OR	CIMZIA® (certolizumab pegol) LYOPHILIZED POWDER (LYO)
INITIAL DOSING CIMZIA STARTER KIT NDC: 50474-710-81 (3 cartons of 2 x 200-mg/mL prefilled syringes) <input type="checkbox"/> Inject 2 syringes (200 mg each) SC at weeks 0, 2, and 4. MAINTENANCE DOSING (PLEASE SELECT ONE SCHEDULE) CIMZIA KIT NDC: 50474-710-79 (1 carton of 2 x 200-mg/mL prefilled syringes) <input type="checkbox"/> Inject 1 syringe (200 mg) SC every 2 weeks. Refills: <input type="checkbox"/> 12 <input type="checkbox"/> Other: _____ (qty must be numerals and words) OR <input type="checkbox"/> Inject 2 syringes (200 mg each) SC every 4 weeks. Refills: <input type="checkbox"/> 12 <input type="checkbox"/> Other: _____ (qty must be numerals and words)		INITIAL DOSING NDC: 50474-700-62 (2 x 200-mg lyophilized powder; 3 kits) <input type="checkbox"/> Initial dose of 400 mg SC at weeks 0, 2, and 4. MAINTENANCE DOSING (PLEASE SELECT ONE SCHEDULE) NDC: 50474-700-62 (2 x 200-mg lyophilized powder) <input type="checkbox"/> 200 mg SC every 2 weeks. Refills: <input type="checkbox"/> 12 <input type="checkbox"/> Other: _____ (qty must be numerals and words) OR <input type="checkbox"/> 400 mg SC every 4 weeks. Refills: <input type="checkbox"/> 12 <input type="checkbox"/> Other: _____ (qty must be numerals and words)
<input type="checkbox"/> Office to train patient <input type="checkbox"/> Home Health Nurse to train		<input type="checkbox"/> Office to administer <input type="checkbox"/> Home Health Nurse to administer: Initial doses: <input type="checkbox"/> All (OR) <input type="checkbox"/> 1 (Week 0) <input type="checkbox"/> 2 (Week 2) <input type="checkbox"/> 3 (Week 4) Maintenance doses: <input type="checkbox"/> All

I authorize RxCrossroads to be my designated agent as needed to refer my patients' prescriptions to the specialty pharmacy and/or nursing agency, and receive information on the status of the dispensing of the prescriptions and related matters.

Practitioner signature: _____ **Date:** _____

Use as directed by practitioner Dispense as written Substitution allowed Invalid without date

(Prescriber attests this is his/her legal signature. **No stamps.**)

PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION	
<p>I hereby authorize each of my physicians, pharmacists (including any specialty pharmacy that receives my prescription for CIMZIA® [certolizumab pegol]), and other healthcare providers (together, "Providers"), and each of my health insurers (together, "Insurers") to disclose my protected health information, including but not limited to information related to my medical condition and treatment (including prescription information), my health insurance coverage, my name, address, telephone number, Social Security number, and insurance number (together, "Protected Health Information"), to UCB, Inc. and its agents and representatives (including RxCrossroads®) (together, "UCB"), for the purposes described below. Specifically, I authorize UCB to receive, use, and disclose my Protected Health Information in order to (i) enroll me in, and contact me about, CIMZIA support programs; (ii) provide me with educational materials, information, and services related to CIMZIA; (iii) verify, investigate, assist with, and coordinate my coverage for CIMZIA with my Insurers; (iv) conduct market analyses or other commercial activity, including aggregating my Protected Health Information with other data for such analyses; (v) assist with analysis related to quality, efficacy, and safety for CIMZIA; and (vi) deidentify my Protected Health Information for use for any purpose under applicable law. UCB may also further use and disclose my Protected Health Information as required or permitted by law. I understand that once my Protected Health Information has been disclosed to UCB, federal privacy laws may no longer protect the information and that my Protected Health Information may be subject to re-disclosure. I understand that I am not required to sign this Authorization. If I do not sign, my treatment (including the receipt of CIMZIA), payment for treatment, insurance enrollment, or eligibility for insurance benefits, will not be directly affected, but I will not be eligible for enrollment in CIMZIA support programs and may not receive the other services described above. I understand that I may cancel (revoke) this Authorization at any time by mailing a letter requesting such revocation to: CIMplicity, c/o RxCrossroads, Inc., PO Box 18708, Louisville, KY 40261. UCB shall provide timely notification of my cancellation (revocation) to my Providers and Insurers. Once my Providers and Insurers receive and process the notice of cancellation (revocation) of this Authorization, my Providers and Insurers may no longer make disclosures of my Protected Health Information to UCB. However, cancelling this Authorization will not affect UCB's ability to use and disclose Protected Health Information that it has already received (unless the laws of my state prevent UCB from continuing to use and disclose such Protected Health Information). This authorization expires on December 31, 2012. I understand that I have a right to receive a copy of this authorization.</p>	
Patient/legal representative name and relationship: _____	Signature: _____ Date: _____