

Complete and fax to 1-866-949-2469



CIMplicity™ Practitioner Registration and Change of Address Form

You will need to submit this form only once. After you have completed this form, fax it to the CIMplicity service center. You will then be registered with CIMplicity, a multifaceted program that provides support for you, your patients, and your practice in all aspects of CIMZIA treatment.

PRACTITIONER INFORMATION			
Last name	First name	Professional title	
Practice name/Clinic/Institution/Hospital		Specialty	
DEA #	Tax ID #	NPI #	State license #
PRIMARY OFFICE ADDRESS			
Street address		Suite #	
City	State	ZIP	
Phone	Fax	E-mail	
SECONDARY OFFICE ADDRESS			
Street address		Suite #	
City	State	ZIP	
Phone	Fax	E-mail	
OFFICE CONTACT			
Primary contact		Phone	

I authorize RxCrossroads® to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use, disclose and receive any protected health information (as defined in 45 CFR 160.103) ("PHI") about any of my patients enrolled with the CIMplicity Program ("Patients"), including exchanging such information with specialty pharmacies, insurers and nurse agencies/coordinators as needed to perform the following services for me: (i) refer my Patients' prescriptions to the specialty pharmacy and receive information on the status of the dispensing of the prescriptions and related matters; (ii) obtain any benefits information about my Patients for purposes of determining the Patient's insurance coverage for CIMZIA and related medical services; (iii) arrange for the provision of nursing services for my Patients to provide any needed injection training or administration and receive information on the status of such nursing services; and (iv) perform adherence or compliance calls to my Patients. RxCrossroads may also use and disclose such PHI to assist me with other functions related to my treatment, payment and/or health care operations, and as otherwise permitted or required by law. As my business associate, RxCrossroads is required to comply with, and by its signature hereto, agrees that it will comply with, the applicable requirements of 45 CFR 164.504(e)(2)(ii)(A) through (I) and 45 CFR 164.314(a)(2)(i)(A) through (C) regarding business associates, and that it will safeguard any PHI that it obtains on my behalf and will use and disclose this information only as permitted herein. RxCrossroads acknowledges that if it materially breaches its obligations as stated herein, I may terminate its services as stated above and this agreement.

Practitioner signature:	Date: / /
Please let us know the best day and time to reach you: <input type="checkbox"/> Mon Time: _____ <input type="checkbox"/> Tue Time: _____ <input type="checkbox"/> Wed Time: _____ <input type="checkbox"/> Thu Time: _____ <input type="checkbox"/> Fri Time: _____	
Please check the preferred means of communication with your office: <input type="checkbox"/> Phone <input type="checkbox"/> Fax <input type="checkbox"/> E-mail	
Do you have appropriate storage for a product that requires refrigeration? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Preferred specialty pharmacy, if any:	
Additional comments:	

Service center signature: <i>Christi Spencer</i>	Date: 09/27/10
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Please ask Sales Representative for full Prescribing Information or visit www.cimzia.com.

For more information, contact the **CIMplicity™** service center:

Hours 8:00 AM to 8:00 PM, EST, Monday through Friday **Fax** 1-866-949-2469

Phone 1-866-4-CIMZIA (1-866-424-6942) **Web site** www.cimzia.com

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