Cimzia Injection Order

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

*Please fax a copy of the following patient information:

❒ Demographics ❒ Insurance Information ❒ Current Medications
❒ H & P Relevant to Diagnosis ❒ Current CBC & CMP
❒ Hep B Results ❒ TB Results

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

CIMZIA DOSAGE

Date of Last Treatment, If Continuation:

❍ **LOADING** **400 mg subcutaneous injection**
Administer at week 0, 2, 4

❍ **MAINTENANCE** ❒ **400 mg SQ every 4 weeks (Crohn's disease)**

❒ **200 mg SQ every 2 weeks**