Complete and Fax to 1-866-949-2469

cimplicity™

cimzia® (certolizumab pegol)

Patient Referral and CIMZIA Prescription Form

☐ New Patient ☐ Re-verification

PATIENT INFORMATION *Please provide physical address, no P.O. Boxes*	PRACTITIONER INFORMATION
Patient name (last, first)	Practitioner name (last, first)
DOB SSN # Gender: M ☐ F ☐	DEA # Tax ID # State Lic #
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 *Please fax a copy of the front AND back of insurance card(s).*	
Primary insurance	Pharmacy benefit or secondary insurance
Primary insurer phone	Insurer phone
Policyholder name	Policyholder name
DOB SSN #	Policy #
Policy # Group #	Group/Bin #

PRESCRIPTION INFORMATION

Prior History:

☐ 5-ASA
☐ Immunosuppressants (6-MP or other)
☐ Corticosteroids
☐ Methotrexate
☐ Surgery
☐ Other _____

Prior Biologic Use

☐ Remicade
☐ Enbrel®
☐ Humira
☐ Orencia®
☐ Simponi™
☐ Rituxan®

Primary diagnosis (ICD-9-CM):

CD: ☐ 555.0 ☐ 555.1 ☐ 555.2 ☐ 555.9
RA: ☐ 714.0 ☐ 714.2 ☐ Other _____
Date of diagnosis: ___/___/___

Choose ONE formulation Rx: Cimzia® (certolizumab pegol)

☐ NDC: 50474-710-79 (2 x 200 mg) prefilled syringes (PFS)
☐ NDC: 50474-700-62 (2 x 200 mg) lyophilized powder (LYO)

Is patient currently on CIMZIA or another biologic? ☐ Y ☐ N

If yes, date to start Cimzia (or date next Cimzia dose due): ___/___/___

Deliver to: ☐ Patient's home ☐ Physician's office

Drug Allergies: _____

☐ **NKDA** **Date of last TB Test:** ___/___/___

☐ Initial dose of 400 mg SC (four hundred mg SC) at weeks 0, 2, and 4

PLEASE CHECK ONE MAINTENANCE DOSE

☐ Maintenance dose of 400 mg SC (four hundred mg SC) every 4 weeks
☐ Maintenance dose of 200 mg SC (two hundred mg SC) every 2 weeks

Refills: ☐ 12 (twelve) ☐ Other qty (must be numerals and words)

_____

HOME HEALTH NURSING SUPPORT *(Optional- If NOT checked, it is assumed NO HHN needed)*

LYOPHILIZED POWDER FORMULATION

☐ No - Office to administer ☐ Yes - Home Health Nurse to administer

IF YES, CHECK DOSES TO BE ADMINISTERED: Initial doses: ☐ All (OR)
☐ 1 (Week 0) ☐ 2 (Week 2) ☐ 3 (Week 4) Maintenance doses: ☐ All

PREFILLED SYRINGE FORMULATION

☐ No - Office to train patient
☐ Yes - Home Health Nurse to train

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:

Invalid Without Date

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

_____ **Dispense as written**

_____ **Substitution allowed**

Date: ___/___/___
☐ **Use as directed by practitioner**

PATIENT AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION

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.

Patient/legal representative name and relationship: _____

Signature: _____ **Date:** ___/___/___

Please ask Sales Representative or Business Specialist 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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