

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

DOB:	Patient Name:	Patient Phone:	
Patient Address:		Patient Email:	
NKDA	Allergies:	Weight (lbs/kg):	Height:
ICD-10 code (required):	ICD-10 description:	Last Treatment Date:	Last 4 SSN:

PROVIDER INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

NURSING

Infusion to be administered per BioHealth protocols.

LABORATORY ORDERS

CBC at each dose every _____
 CMP at each dose every _____
 CRP at each dose every _____
 OTHER _____

PREMEDICATIONS

acetaminophen (Tylenol) 500mg 650mg / 1000mg PO
 cetirizine (Zyrtec) 10mg PO
 loratadine (Claritin) 10mg PO
 diphenhydramine (Benadryl) 25mg 50mg PO IV
 methylprednisolone (Solu-Medrol) 40mg 125mg IV
 hydrocortisone (Solu-Cortef) 100mg IV
 Other: _____
 Dose: _____ Route: _____
 Frequency: _____

CIMZIA THERAPY ADMINISTRATION

_____ mg injection on week 0, 2, 4 and every _____ weeks

_____ mg injection every _____ weeks

REQUIRED DOCUMENTATION

Patient Demographics	Hep B Core (if available)
Insurance Card/Information	Hep B Surface Ag (within 36 months)
Progress Notes Supporting Dx	TB results (within 6 months)
Medication List and H&P	

*Consider administering premedication for prophylaxis against infusion reactions and hypersensitivity reactions. **Order is valid for one year unless otherwise noted.**

Provider Name (Print)	Provider Signature	Date
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Have a Question? (786)460-6044
 Fax Referral Form To: (786)219-3917
 8684 SUNSET DRIVE MIAMI FL 33143