

Certolizumab (Cimzia)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____ Patient Phone: _____
Patient Address: _____ Patient Email: _____
Allergies: _____ NKDA Weight (lbs/kg): _____ Height (in/cm): _____
Sex: M / F Date of Last Infusion: _____ Next Due Date: _____ Preferred Location: _____

DIAGNOSIS (Please provide ICD-10 code in space provided)

RA w/rheumatoid factor, multiple sites: _____ RA w/o rheumatoid factor, multiple sites: _____
Rheumatoid arthritis of unspecified site with involvement of organs and systems: _____
Arthropathic psoriasis, unspecified: _____ Other psoriatic arthropathy: _____
Ankylosing spondylitis of unspec sites in spine: _____ Ankylosing spondylitis of multiple sites in spine: _____
psoriatic vulgaris (plaque psoriasis): _____ other psoriasis: _____ psoriasis, unspecified: _____
Other: _____ Description: _____

THERAPY ADMINISTRATION & DOSING

- Induction: Cimzia 400mg (2 sub-q 200mg injections) On week 0, week 2 and week 4
 Maintenance: Cimzia 200mg
 Maintenance: Cimzia 400mg
 Following initial Cimzia treatment, observe patient for 15 minutes for hypersensitivity.

MAINTENANCE DOSE FREQUENCY (Choose one)

- Maintenance: every 2 weeks
 Maintenance: every 4 weeks

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

Other: _____

NURSING

- Hold infusion and notify provider for:
- Signs or symptoms of illness/active infection or cough, night sweats, weight loss or neurological changes
 - HBV positive carrier (contraindicated) or signs or symptoms of HBV
 - Planned/recent surgical procedures or recent live vaccinations
- Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: _____ Preferred Contact Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

REQUIRED DOCUMENTATION CHECKLIST (Additional documentation required for processing and insurance approval)

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, colonoscopy (by indication)

Required Labs: Negative TB within 12 months, Negative Hep B, CRP, ESR. For RA: Rheumatoid factor, CCP, For CD/UC: Fecal Calpro

Provider Name (print)

Provider Signature

Date

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.