Certolizumab (Cimzia)

Provider Order Form rev. 05/30/2024

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.