

# CIMZIA (CERTOLIZUMAB) ORDER FORM

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

## DIAGNOSIS (Provider must specify)

- Crohn's Disease, ICD 10: K50.\_\_\_\_\_  Rheumatoid Arthritis, ICD 10: M05.\_\_\_\_\_ or M06.\_\_\_\_\_ or M45.\_\_\_\_\_
- Psoriatic Arthritis, ICD 10: L40.\_\_\_\_\_
- Other: \_\_\_\_\_

## PROVIDER INFORMATION

Provider Name (print name): \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Prerequisites to treatment** – ensure the following information is complete and attached with referral:

- Demographics  Labs and tests supporting diagnosis  Office/progress notes

## PRE-MEDICATION (Not typically indicated)

- Acetaminophen (Tylenol) 500 mg PO  Famotidine 20 mg IV  Methylprednisolone (Solu-Medrol) 125 mg IVP
- Benadryl 25mg PO  Cetirizine (Zyrtec) 10 mg PO
- Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

## MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Cimzia	<input type="checkbox"/> 200 mg <input type="checkbox"/> 400 mg	<input type="checkbox"/> Subcutaneous inj.	<input type="checkbox"/> Every 2 weeks x2, then every 4 weeks <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks

New Start Therapy  Continuation of Therapy Date of last dose (if applicable): \_\_\_\_\_

## LABS / SPECIAL INSTRUCTIONS