

CIMZIA® (certolizumab pegol)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List TB Test
 Clinical/Progress Notes Supporting Dx Hep B Test Results Recent Lab Results

Primary Diagnosis

-  ICD-10 Code (required): _____
 Plaque psoriasis Crohn's disease Other: _____
 Psoriatic arthritis Ankylosing Spondylitis
 Rheumatoid arthritis Non-radiographic Axial Spondylitis

Therapy Administration

Crohns Disease:

- Cimzia 400mg subQ week 0, 2, 4 followed by 400mg subQ every 4 weeks thereafter

Plaque Psoriasis:

- Cimzia 400mg subQ every other week

Refills:

- x 1 year Other: _____  Order valid for one year unless otherwise stated

Rheumatoid Arthritis/Psoriatic Arthritis/Ankylosing Spondylitis/Non-radiographic Axial Spondylitis:

- Cimzia 400mg subQ week 0, 2, 4 followed by 200mg subQ every 2 weeks thereafter
 Cimzia 400mg subQ week 0, 2, 4 followed by 400mg subQ every 4 weeks thereafter

- Other: _____

Special Instructions

- Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy) Other: Please fax alternative reaction orders or nursing administration orders if checking this box
 RN to administer ordered therapy per manufacturer guidelines.

Lab Orders

- CBC at each dose every _____ CRP at each dose every _____
 CMP at each dose every _____ Other: _____

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____