

CERTOLIZUMAB (CIMZIA®) PRESCRIBER ORDER FORM

Patient Name: _____

Date of Birth: _____

Gender: _____

Address: _____

Patient Phone: _____

Height: _____

 inches cm

Weight: _____

 lbs. kg**Clinical Information**

Primary Diagnosis Description: _____

ICD-10 Code: _____

Is this the first dose?

 Yes – date of first dose: _____ No – date of last dose: _____

Hepatitis B Status: _____

Titer Date: _____

 Positive Negative

TB Status: _____

 PPD (negative) – date: _____ Active TB Last chest x-ray – date: _____ Unknown Quantiferon or T Spot Assay result and date: _____ Past positive TB infection, course taken: _____**Certolizumab (Cimzia®) Prescription**

Certolizumab (Cimzia®) 200 mg/mL Kit refill as directed x 1 year

Initial Dose: Inject 400 mg SUBQ on Weeks 0, 2, and 4. Other: _____Maintenance Dose: Inject 400 mg SUBQ every 4 weeks (Crohn's disease). Inject 200 mg SUBQ every other week or 400 mg every 4 weeks (ankylosing spondylitis). Inject 200 mg SUBQ every other week – consider 400 mg SUBQ every 4 weeks (psoriatic or rheumatoid arthritis). Other: _____**Ancillary Orders****Medication Orders** Other: _____**Lab Orders** No labs ordered at this time. Other: _____*Skilled nurse to assess and administer and/or teach self-administration where appropriate via (IV/SUBQ) access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.**If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.**I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

Prescriber Signature: _____ Date: _____

Prescriber Information

Prescriber Name: _____

Phone: _____

Fax: _____

Address: _____

NPI: _____

City, State: _____

Zip: _____

Office Contact: _____

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