Phone: 608-690-7210
Fax: 608-807-5179
www.MySmartInfusion.com

**Location**

☐ Eau Claire ☐ Weston
☐ Middleton ☐ Onalaska

# **Cimzia** (Certolizumab)

## Subcutaneous Injection Order Form

**Patient Information**

Patient Name: ______________________________________________ DOB: ____________________ M ☐ F ☐

Allergies: _________________________________________________ Allergies to Latex: ☐ Yes ☐ No

☐ New Treatment ☐ Continuing Treatment Last Treatment Date: _____________ Next Due Date: _____________

Diagnosis and ICD 10 Code (Required)

☐ Moderate to Severe Rheumatoid Arthritis ICD 10 Code: M06.9
☐ Moderate to Severe Crohn's Disease ICD 10 Code: K50.90
☐ Moderate to Severe Plaque Psoriasis ICD 10 Code: L40.0
☐ Active Ankylosing Spondylitis ICD 10 Code: M45.9
☐ Active Psoriatic Arthritis ICD 10 Code: L40.52
☐ Active Axial Spondylarthritis ICD 10 Code: M47.9

Required Tests

TB/QuantiFERON (within 12 months & attach results)

Hepatitis B Status & Date: ______________________________

Most recent CBC & CMP (attach results)

Pre-Medication Orders

Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV

Methylprednisolone (Solu-Medrol) ☐ 125mg IV

Ondansetron (Zofran) ☐ 4mg ☐ 8mg ☐ PO ☐ IV

Other: ________________________ Route: ____________

Dose: _____________ Frequency: ____________________

**Cimzia Medication Order**

**Refill x12 months unless otherwise noted: __________**

**Patient Weight**: _____________ KG

Dosage – Subcutaneous Injection

☐ 200mg
☐ 400mg
☐ Other: ____________________ mg

Frequency

☐ Induction week 0, 2, 4 then maintenance dosing
☐ Maintenance every 2 weeks
☐ Maintenance every 4 weeks
☐ Other: ______________________

**Adverse Reaction Management & Nursing Orders**

Full protocols are available for review at mysmartinfusion.com or upon request.

☒ Administer the following emergency medications per Smart Infusion Therapy Services protocol:

- ☒ Acetaminophen 650mg PO,
- ☒ Diphenhydramine 25mg-50mg PO or IV
- ☒ Ondansetron 4mg IV
- ☒ Sodium Chloride 0.9% 1000mL IV
- ☒ Methylprednisolone 125mg IV
- ☒ Albuterol Sulfate 2.5mg nebulized
- ☒ Oxygen 1-6LPM continuous flow
- ☒ Epinephrine 0.3mg/0.3mL IM
- ☐ Other: ______________________

☒ Manage VAD per protocol:

- ☒ Start/Access and Discontinue PIV/CVC
- ☒ Flush with NS and/or Heparin per protocol based on line type
- ☒ Other: ____________

**Required Documents**

☐ Patient Demographic Sheet
☐ H & P within the past 6 months
☐ Current Medication List
☐ Clinical & Progress Notes (including last infusion note)
☐ Copy of Insurance Card (Front/Back)

**Provider Information**

Provider Name: ____________________________________________ Provider NPI: ______________________

Office Phone: __________________________________ Office Fax: __________________________________

Provider Signature: ________________________________________________ Date: ___________________