

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)

- | | | | |
|--|---------------------|--|---------------------|
| <input type="checkbox"/> Moderate to Severe Rheumatoid Arthritis | ICD 10 Code: M06.9 | <input type="checkbox"/> Active Ankylosing Spondylitis | ICD 10 Code: M45.9 |
| <input type="checkbox"/> Moderate to Severe Crohn's Disease | ICD 10 Code: K50.90 | <input type="checkbox"/> Active Psoriatic Arthritis | ICD 10 Code: L40.52 |
| <input type="checkbox"/> Moderate to Severe Plaque Psoriasis | ICD 10 Code: L40.0 | <input type="checkbox"/> 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: _____

Nursing

Provide nursing care per Smart Infusion Nursing Procedures, including reaction management and post-procedure observation.

Special Instructions / Notes

Cimzia Medication Order

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: _____

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)

Location

- Eau Claire Weston Middleton

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____