

## Cimzia (Certolizumab pego) Injection Order

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_  Male  Female

Diagnosis (please provide ICD10 code): \_\_\_\_\_

Other: \_\_\_\_\_

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

New Therapy Order  Continuation of Therapy Date of last dose: \_\_\_\_\_

Ordering Provider Name: \_\_\_\_\_

Provider NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Pre-Medication

- Acetaminophen \_\_\_\_\_mg by  PO
- Cetirizine \_\_\_\_\_mg by  PO
- Diphenhydramine \_\_\_\_\_mg by  PO/  IVP
- Solu-Medrol \_\_\_\_\_mg by  PO/  IVP
- Solu-Cortef \_\_\_\_\_mg by  PO/  IVP
- Other: \_\_\_\_\_

### Required Documentation:

- Patient Demographics
- Patient Insurance (med and pharm card copies, front and back)
- Progress Notes/Labs supporting diagnosis
- Hepatitis B status and date
- CBC, CMP, Quantiferon, ESR, CRP lab results
- Other: \_\_\_\_\_

### Patient height and weight:

Patient Height (cm): \_\_\_\_\_ Patient Weight (kg): \_\_\_\_\_

### Cimzia Medication Order (Please select ONE):

- Subcutaneous Induction dosing on weeks 0, 2 and 4, followed by maintenance
  - Dosing (Please choose one)
    - 400 mg
    - Other: \_\_\_\_\_
  - Maintenance Frequency (Please choose one)
    - Every 2 weeks
    - Every 4 weeks
    - Other: \_\_\_\_\_

- Subcutaneous Maintenance Dosing Only
  - Dosing (Please choose one)
    - 400 mg
    - Other: \_\_\_\_\_
  - Maintenance Frequency (Please choose one)
    - Every 2 weeks
    - Every 4 weeks
    - Other: \_\_\_\_\_

### Additional Instructions/Notes:

### Ordering Provider:

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

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

Provider: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Best Contact Person in Office: \_\_\_\_\_

Phone: \_\_\_\_\_

### Locations:

- Skokie, IL: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
- Libertyville, IL: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
- Houston, TX: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400