



CIMZIA (certolizumab pegol)

PATIENT INFORMATION

PATIENT NAME: _____ PHONE #: _____
 ADDRESS: _____ CITY, STATE, ZIP: _____
 DATE OF BIRTH: _____ EMAIL: _____
 ALLERGIES: SEE LIST NKDA WEIGHT: LB OR KG

REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Most Recent Labs 5. Medication List
 6. Tried/Failed Therapies 7. Negative TB Results 8. Negative Hep B Panel

PRIMARY DIAGNOSIS

- K50.90 Crohn's disease, unspecified, without complications L40.0 Psoriasis vulgaris L40.50 Arthropathic psoriasis, unspecified
 M05.79 Rheumatoid arthritis with rheumatoid factor,w/o org/sys involv M05.9 Rheumatoid Arthritis with rheumatoid factor, unspecified
 M06.00 Rheumatoid arthritis without rheumatoid factor, unsp site M06.89 Other specified rheumatoid arthritis, multiple sites
 M06.9 Rheumatoid arthritis, unspecified Other _____

LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: There are no recommended standard pre-meds for Cimzia
 Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Crohn's Disease: <input type="checkbox"/> Cimzia 400mg subQ injection at week 0, 2, 4, and every 4 weeks thereafter	Ankylosing Spondylitis: <input type="checkbox"/> Cimzia 400mg subQ injection at week 0, 2, 4, and then 200mg subQ Injection every other week thereafter
Rheumatoid Arthritis: <input type="checkbox"/> Cimzia 400mg subQ injection at week 0, 2, 4, and then 200mg subQ Injection every other week thereafter	Non-radiographic Axial Spondyloarthritis: <input type="checkbox"/> Cimzia 400mg subQ injection at week 0, 2, 4, and then 200mg subQ Injection every other week thereafter
Psoriatic Arthritis: <input type="checkbox"/> Cimzia 400mg subQ injection at week 0, 2, 4, and then 200mg subQ Injection every other week thereafter	Plaque Psoriasis: <input type="checkbox"/> Cimzia 400mg subQ injection every other week

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
 Other: (Please send other reaction orders if checking this box)

First Dose? Yes No Refill x 12 months unless otherwise noted _____

PRESCRIBER INFORMATION

PROVIDER NAME: _____ PHONE: _____
 OFFICE CONTACT: _____ FAX: _____
 ADDRESS: _____ EMAIL: _____
 CITY, STATE, ZIP: _____ NPI AND LICENSE: _____

X

PROVIDER SIGNATURE _____ DATE _____