Cimzia Order Form
(certolizumab pegol)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

ICD 10 Code (PROVIDE COMPLETE CODE)

- ☐ K50.0_____ Crohn's Disease, Small Intestine
- ☐ K50.1_____ Crohn's Disease, Large Intestine
- ☐ K50.8_____ Crohn's Disease, Small & Large Intestine
- ☐ K50.9_____ Crohn's Disease, Unspecified
- ☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
- ☐ L40.50 Arthropathic Psoriasis
- ☐ L40.52 Psoriatic Arthritis
- ☐ L40.59 Other Psoriatic Arthropathy
- ☐ L40.9 Psoriasis, Unspecified
- ☐ M05.0_____ Felty's Syndrome
- ☐ M05. _____ Rheumatoid Arthritis, w/ Rheumatoid Factor
- ☐ M06._____ Rheumatoid Arthritis, w/o Rheumatoid Factor
- ☐ M45._____ Ankylosing Spondylitis
- ☐ M46.8 _____ Non-Radiographic Axial Spondylarthritis

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Include Negative Hepatitis B within 3 years & Negative TB within 12 months.**

PRESCRIPTION

Lab Orders

Required: Negative TB, annually

+Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider.

Cimzia (certolizumab pegol)

Loading Dose:

☐ **SubQ:** Inject 400 mg at weeks 0, 2, and 4

Maintenance: **(SELECT ONE)**

☐ **SubQ:** Inject 200 mg every 2 weeks for one year

☐ **SubQ:** Inject 400 mg every 4 weeks for one year

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first injection.

Comments: _____

_____

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ ***Signature:*** _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____