


CERTOLIZUMAB (CIMZIA®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

	Patient Name:		Date of Birth:		
	Address:				
	Patient Phone:		Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:

Clinical Information

Primary Diagnosis Description:			ICD-10 Code:		
Is this the first dose?		Hepatitis B Status:		Titer Date:	
<input type="checkbox"/> Yes – date of first dose: <input type="checkbox"/> No – date of next dose due:		<input type="checkbox"/> Positive <input type="checkbox"/> Negative		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
TB Status:	<input type="checkbox"/> PPD (negative) – date:		<input type="checkbox"/> Active TB		
	<input type="checkbox"/> Last chest x-ray – date:		<input type="checkbox"/> Unknown		
	<input type="checkbox"/> Past positive TB infection, course taken:				

Certolizumab (Cimzia®) Prescription

Certolizumab (Cimzia®) 200 mg/mL Kit refill as directed x 1 year

Initial Dose: Inject 400 mg SQ on Weeks 0, 2, and 4.

Other: _____

Maintenance Dose: Inject 400 mg SQ every 4 weeks (Crohn's disease).

Inject 200 mg SQ every other week or 400 mg every 4 weeks (ankylosing spondylitis).

Inject 200 mg SQ every other week – consider 400 mg SQ every 4 weeks (psoriatic or rheumatoid arthritis).

Other: _____

Ancillary Orders

Medication Orders

Other: _____

Lab Orders

No labs ordered at this time.

Other: _____

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:		Phone:	Fax:
Address:		NPI:	
City, State:	Zip:	Office Contact:	

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