CERTOLIZUMAB (CIMZIA®) PRESCRIBER ORDER FORM

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

option care health™

Patient Name:			**Date of Birth:**	
Address:				
Patient Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs. ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Is this the first dose?	☐ Yes – date of first dose: ☐ No – date of next dose due:	**Hepatitis B Status:**	Titer Date: ☐ Positive ☐ Negative

TB Status:	☐ PPD (negative) – date: ☐ Last chest x-ray – date: ☐ Past positive TB infection, course taken:	☐ Active TB ☐ Unknown

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:**

