CERTOLIZUMAB (CIMZIA®) PRESCRIBER ORDER FORM

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: _____
☐ Quantiferon or T Spot Assay result and 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 SUBQ on Weeks 0, 2, and 4.

☐ Other: _____

Maintenance Dose: ☐ Inject 400 mg SUBQ every 4 weeks (Crohn's disease).
☐ Inject 200 mg SUBQ every other week or 400 mg every 4 weeks (ankylosing spondylitis).
☐ Inject 200 mg SUBQ every other week – ☐ consider 400 mg SUBQ every 4 weeks (psoriatic or rheumatoid arthritis).

☐ Other: _____

Ancillary Orders

Medication Orders

☐ Other: _____

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration where appropriate via (IV/SUBQ) access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

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:**

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

