

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: _____ Active TB Last chest x-ray – date: _____ Unknown Quantiferon or T Spot Assay result and date: _____ 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 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:

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