Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265 DOB: _____

STANDARD CIMZIA PLAN OF TREATMENT for GASTROENTEROLOGY

(Re)Certification Period from _____ to _____

NOTE: Patient is ***ineligible*** to receive Cimzia if receiving antibiotic for active infectious process (due to the possibility of developing a super-infection related to its effect on the immune status), or if he/she has a suspected infection.

Patient's Name _____ HT: _____ WT: _____ Allergies: _____

DIAGNOSIS: ☐ 555.0 Crohn's Disease (small intestine) ☐ 555.1 Crohn's Disease (large intestine)
☐ 555.2 Crohn's Disease (small & large intestine) ☐ 555.9 Regional enteritis unspecified site

Physician Office to Complete:

1. **Has your patient had failure, intolerance, or contraindication to conventional therapy?**
   ☐ **Yes** ☐ **No**
2. **If yes, please specify, treatment/medication tried and outcomes:_____**
   _____

Obtain weight each visit. Vital signs baseline then 30 minutes post injection for the first 3 treatments, then may discharge after injection. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient for response to therapy. Supplies needed to complete prescribed therapy.

If adverse drug reaction, implement the Standing Adverse Reaction Protocol.

Loading dose:

☐ **Cimzia 400 mgs subq at week 0, 2, 4**

Maintenance dose as follows:

☐ **Cimzia 200mgs subq every 2 weeks**
OR
☐ **Cimzia 400mgs subq every 4 weeks**

Other: Pharmacist to perform clinical drug monitoring.

(no stamped signatures please)

Physician's Signature: _____ _____ Date: _____
(Dispense as written) (Substitution permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920

Patient should have a negative PPD within 6 months, documented absence of active TB, as well as documented Hep B surface antigen.

Does the patient have a history of (circle each): TB SOB Cough Night Sweats Fever Weight Loss None
Has the patient had recent exposure to TB or been out of the country in the past month? ☐ Yes ☐No
Does the patient have a family history of TB? ☐Yes ☐No Chest X-Ray: ☐ Yes ☐No Results: _____
Has the patient had a PPD test? ☐Yes ☐No Date _____ Results _____ **Palmetto must have copy on file**
Any previous treatment for TB? ☐Yes ☐No
Has patient received ***TNF therapy in past 6 months?*** ☐Yes ☐No Therapy: _____ Last date Received:_____
Hep B surface antigen drawn: ☐Yes ☐No Please fax results with referral along with PPD results