

Phone: 800-809-1265

MRN: \_\_\_\_\_

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