

Phone: 800-809-1265

MRN: _____

DOB: _____

STANDARD CIMZIA PLAN OF TREATMENT

(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: 714.0 Rheumatoid Arthritis 714.2 Other Rheumatoid Arthritis
 720.0 Ankylosing Spondylitis 696.0 Psoriatic Arthropathy**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 NoDoes 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 NoHas 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