



MRN: _____
DOB: _____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

STANDARD Cimzia® (certolizumab pegol) Plan of Treatment for Rheumatology

NOTE: Patient may be ineligible to receive Cimzia® if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new or worsening symptoms of CHF, new-onset or deterioration neurological changes, and/or surgery.

1. Patient Name: _____ Height (inches): _____ Weight (lbs): _____

2. Allergies: _____

3. Diagnosis: * Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing

- M05._____ Rheumatoid Arthritis with Rheumatoid factor L40.5_____ Psoriatic Arthropathy
- M06._____ Rheumatoid Arthritis without Rheumatoid factor M45._____ Ankylosing Spondylitis
- L40._____ Plaque Psoriasis Other ICD-10/Diagnosis description: _____

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4. Dose/Frequency:

Induction dose:

_____ Cimzia® (certolizumab pegol) 400mgs subcutaneous injection at 0 week, 2 week, and 4 weeks
(Administer as 2 divided subcutaneous injections with 23-gauge needle to separate sites 1n the abdomen or thigh only)

Maintenance dose as follows:

_____ Cimzia® (certolizumab pegol) 200mgs subcutaneous injection every 2 weeks
(Administer as 1 subcutaneous injection with 23- gauge needle to the abdomen or thigh only)

_____ Cimzia® (certolizumab pegol) 400mgs subcutaneous injection every 4 weeks
(Administer as 2 divided subcutaneous injections with 23-gauge needle to separate sites in the abdomen or thigh only)

Special orders: _____

If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES

5. Physician's Signature: _____ / _____ Date: _____
No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____ NPI: _____

6. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms and Adverse Drug Reaction Guidelines are available at www.palmettoinfusion.com



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Guidelines for Prescribing Cimzia® (certolizumab pegol) for Rheumatology

(Required documentation with all initial referrals)

Patient Name: _____

Referral Date: _____

___ Include signed and completed **Plan of Treatment**. (MD must complete sections 1-6)
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

- CIMZIA® is indicated for **Rheumatoid Arthritis, Psoriatic Arthritis, and Ankylosing Spondylitis** at dose of 400 mg subcutaneous injections initially and at weeks 2 and 4. Followed by maintenance dose of 200 mg every other week or 400 mg every 4 weeks as clinically indicated.
- CIMZIA® is indicated for Plaque Psoriasis at dose of 400 mg subcutaneous injections every other week. For some patients (with body weight ≤ 90 kg), a dose of 400 mg initially and at week 2 and 4, followed by 200 mg every other week may be considered.

___ If patient is switching biological therapies, then MD must specify wash-out period prior to starting CIMZIA® as specified of _____ weeks. Last known biological therapy: _____ and last date received: _____. (Include copy of last CIMZIA® injection record if available and currently on therapy)

___ Other as requested: _____

Pre-Screening: (TB and Hepatitis screening results must be available prior to start of therapy and within last 12 months.)

___ **Required TB screening results: PPD or QuantiFERON Gold Test.**
(* If screening results are positive or indeterminate, then a negative CXR result is required.)

___ **Required Hepatitis screening to include: Hepatitis B Surface Antigen results.**

**** Warnings/Precautions:** Cimzia® (certolizumab pegol) may increase the **risk of infections** and reactivation of latent infections. **Heart failure:** worsening or new onset may occur. **Hepatitis B virus reactivation:** test for HBV infection before starting CIMZIA®. Monitor HBV carriers during and several months after therapy. If reactivation occurs, stop CIMZIA® and begin anti-viral therapy. **Demyelinating disease:** exacerbation or new onset, may occur. **Cytopenias, pancytopenia:** advise patients to seek immediate medical attention if symptoms develop and consider stopping CIMZIA®. **Lupus-like syndrome:** stop CIMZIA® if syndrome develops. Evaluation of immunizations should be completed prior to and **live vaccines** should not be given before or concurrently with CIMZIA® See full prescribing information.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient’s insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.