



MRN: _____

DOB: _____

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

STANDARD Cimzia® (certolizumab pegol) PLAN OF TREATMENT FOR GASTROENTEROLOGY

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

K50.0 _____ Crohn's Disease (small intestine) **K50.8** _____ Crohn's Disease (small & large intestine)

K50.1 _____ Crohn's Disease (large intestine) **K50.9** _____ Crohn's Disease, Unspecified

Other **ICD-10 Code:** _____ **Diagnosis description:** _____

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4. Dose/Frequency:

Cimzia® (certolizumab pegol) 400mgs subcutaneous injection administered as 2 *divided subcutaneous injections with 23-gauge needle to separate sites in the abdomen or thigh only.*

Induction dose at 0 week, 2 week, and 4 weeks

Maintenance dose every 4 weeks (No < 28 days)

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 Gastroenterology (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 reducing signs and symptoms of Crohn’s disease and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy. The recommended initial adult dose of CIMZIA® is 400 mg initially, and at weeks 2 and 4. In patients who obtain a clinical response, the recommended maintenance regimen is 400 mg every four weeks.

___ 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:

___ **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.