MRN:_____

DOB:_____

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:** _____

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: _____
(Dispense as written) (Substitution permitted)

No Stamp Signatures

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

MRN:_____

DOB:_____

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**.

☐ 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:

☐ **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.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.