Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Cimzia® (certolizumab pegol) Standard Plan of Treatment for Gastroenterology

PATIENT DEMOGRAPHICS:

Date of Referral:				Patient's Phone:			
Patient Name:				Address:			
Date of Birth:				City, State, Zip:			
Height in inches:	Weight:	LB or	KG	Gender:	Allergies:	☐ See list	☐ NDKA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

- ☐ K50.____ - Crohn's disease (small instestine)
- ☐ K50.1 - Crohn's disease (large intestine)
- ☐ K50.8 - Crohn's disease (small & large intestine)
- ☐ K50.9 - Crohn's disease, unspecified
- ☐ _____ - Other: _____

REQUESTED DOCUMENTATION:

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
3	Full medication list		NEXT INJECTION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** TB screening for new start patients		☐ **Continue current order until insurance approved**
6	HBV screening/labs as required by payor		

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive certolizumab pegol 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.

DOSE/FREQUENCY:

- ☐ Induction: Cimzia® (certolizumab pegol) 400mg at week 0, week 2, week 4, and every 4 weeks thereafter
- ☐ Maintenance: Cimzia® (certolizumab pegol) 400mg every 4 weeks

Administer as 2 divided subcutaneous injections to separate sites in the abdomen or thigh only

SPECIAL ORDERS:

- ☐ _____

Prescriber confirms that the patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment. Prescriber to monitor patient for symptoms of HBV and TB infection and reactivation as clinically appropriate.

☑ Refills x 12 months unless noted otherwise here:

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE
Dispense as written/Brand medically necessary	Substitution permitted	

Palmetto
INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- ☐ **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**

Palmetto Infusion 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com

02/10/2023