Palmetto INFUSION®

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

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

Cimzia® (certolizumab pegol) Standard Plan of Treatment for Rheumatology & Dermatology

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)

☐	M05. ____ - Rheumatoid Arthritis with rheumatoid factor	☐	M45.A ___ - Non-radiographic axial spondyloarthritis
☐	M06. ____ - Rheumatoid Arthritis without rheumatoid factor	☐	L40.0 - Psoriasis vulgaris
☐	M45. ____ - Ankylosing Spondylitis	☐	L40.5 ___ - Arthropathic psoriasis
☐	M46.8 ___ - Other specified inflammatory spondylopathies	☐	L40.9 - Psoriasis, unspecifed
☐	_____ - Other: _____		

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	**REQUIRED:** TB screening for new start patients
6	HBV screening/labs as required by payor

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INJECTION DATE:
	NEXT INJECTION DATE:
	IF ORDER CHANGE:
	☐ **Continue current order until insurance approved**

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 maintenance as indicated below
- ☐ Maintenance: Cimzia® (certolizumab pegol) 200mg every 2 weeks
- ☐ 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	