

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> 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:
<input type="checkbox"/> See list	<input type="checkbox"/> 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, unspecified
___ - Other:	

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	TB screening
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 every 4 weeks thereafter

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 infection and reactivation as clinically appropriate.

Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

Start PIV/Access CVC

Flush device per facility standard flushing procedure

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	