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 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 ☐ NKDA	

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:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
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		

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:

NURSING ORDERS:	ADVERSE REACTION & ANAPHYLAXIS ORDERS:
☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated.	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	