

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 Gastroenterology

Rev 4.28.25

### PATIENT DEMOGRAPHICS:

Patient Name:			
Patient's Phone:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight:	LB or KG Gender:	Allergies:
			<input type="checkbox"/> See list <input type="checkbox"/> NKDA

### DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

<input type="checkbox"/> K50.____ - Crohn's disease (small intestine)
<input type="checkbox"/> K50.1 - Crohn's disease (large intestine)
<input type="checkbox"/> K50.8 - Crohn's disease (small & large intestine)
<input type="checkbox"/> K50.9 - Crohn's disease, unspecified
<input type="checkbox"/> _____ - 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	LAST INJECTION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INJECTION DATE:
4	Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b>
5	<b>REQUIRED:</b> TB screening for new start patients	THERAPY:	
6	HBV screening/labs as required by payor		
			<b>Continue current order until insurance approved</b>

### 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:

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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:

<input checked="" type="checkbox"/> 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.
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### 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	