

Boca Raton
9980 Central Park Blvd
Suite 202, N
Boca Raton, FL 33428



(certolizumab pegol)

CIMZIA infusion orders

Date: _____

| PATIENT INFORMATION | | |
|------------------------------------------|---------------------|------------------------------------------------------------|
| Name: | DOB: | SEX: M <input type="checkbox"/> F <input type="checkbox"/> |
| ICD-10 code (required): | ICD-10 description: | |
| <input type="checkbox"/> NKDA Allergies: | Weight lbs/kg: | |

| REFERRAL STATUS | |
|--------------------------------------------------|-----------------------------------------------------|
| <input type="checkbox"/> New Referral | <input type="checkbox"/> Referral Renewal |
| <input type="checkbox"/> Medication/Order Change | <input type="checkbox"/> Benefits Verification Only |
| <input type="checkbox"/> Discontinuation Order | |

| PHYSICIAN INFORMATION | |
|----------------------------|-----------------------------|
| Referral Coordinator Name: | Referral Coordinator Email: |
| Ordering Provider: | Provider NPI: |
| Referring Practice Name: | Phone: Fax: |
| Practice Address: | City: State: Zip Code: |

DIAGNOSIS *Please provide ICD-10 code*

_____ Rheumatoid Arthritis
 _____ Crohn's Disease
 _____ Ankylosing Spondylitis
 _____ Psoriatic Arthritis
 _____ (other)

PRE-MEDICATION

Tylenol 1000mg PO Solu-Medrol 125mg IVP
 Diphenhydramine 25mg PO Solu-Cortef 100mg IVP
 Cetirizine 10mg PO Diphenhydramine 25mg IVP
 _____ (other) _____ (other)

CIMZIA ORDERS

PATIENT WEIGHT

_____ lbs.
_____ kg

DOSAGE/FREQUENCY:

400mg SQ initially and at Weeks 2 and 4 (*induction*)
 200mg SQ every 2 weeks (*maintenance*)
 400mg SQ every 4 weeks

TB TESTING

Perform QuantiFERON Gold (QFT Gold)
 Perform PPD Skin Test

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____