(certolizumab pegol)

CIMZIA infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

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

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____ *(other)*
☐ Length of Need _____
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ *(other)*

CIMZIA ORDERS

DOSAGE/FREQUENCY

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

PATIENT WEIGHT

_____ lbs.
_____ kg

TB TESTING

☐ Perform Quantiferon Gold (QFT Gold)
☐ Perform PPD Skin Test

◯ Refills: _____

Notes

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Address _____

_____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887