

# CERTOLIZUMAB (CIMZIA®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:



Patient Name:		Date of Birth:	
Address:			
Patient Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight: <input type="checkbox"/> lbs. <input type="checkbox"/> kg

### Clinical Information

Primary Diagnosis Description:		ICD-10 Code:	
Is this the first dose? <input type="checkbox"/> Yes – date of first dose: <input type="checkbox"/> No – date of next dose due:		Hepatitis B Status: <input type="checkbox"/> Active TB <input type="checkbox"/> Unknown	Titer Date: <input type="checkbox"/> Positive <input type="checkbox"/> Negative
TB Status:	<input type="checkbox"/> PPD (negative) – date: <input type="checkbox"/> Last chest x-ray – date: <input type="checkbox"/> Past positive TB infection, course taken:		

### Certolizumab (Cimzia®) Prescription

Certolizumab (Cimzia®) 200 mg/mL Kit refill as directed x 1 year

**Initial Dose:**  Inject 400 mg SQ on Weeks 0, 2, and 4.  
 Other: \_\_\_\_\_

**Maintenance Dose:**  Inject 400 mg SQ every 4 weeks (Crohn's disease).  
 Inject 200 mg SQ every other week or 400 mg every 4 weeks (ankylosing spondylitis).  
 Inject 200 mg SQ every other week –  consider 400 mg SQ every 4 weeks (psoriatic or rheumatoid arthritis).  
 Other: \_\_\_\_\_

### Ancillary Orders

#### Medication Orders

Other: \_\_\_\_\_

#### Lab Orders

No labs ordered at this time.  
 Other: \_\_\_\_\_

*I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.*

Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Prescriber Information

Prescriber Name:	Phone:	Fax:
Address:	NPI:	
City, State:	Zip:	Office Contact:

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