Patient Name:_____

DOB:_____ Wt(kg):_____

Allergies:_____ Phone:_____

CIMZIA (CERTOLIZUMAB PEGOL)
SUB-Q ORDERS

****REQUIRED INFORMATION****

☐ This signed order form from the provider
☐ Patient demographics & insurance information
☐ **Clinical/Progress Notes, Labs & Tests** supporting primary diagnosis
☐ TB Test Attached ☐ Perform TB Testing
☐ **TB Protocol:** Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(Optional)*
☐ **Hepatitis B Protocol:** Hep B surface antigen and Hep B Core AB total required.

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis:

☐ Crohn's Disease (ICD-10 Code:_____)
☐ Ankylosing Spondylitis (ICD-10 Code: _____)
☐ Psoriatic Arthritis (ICD-10 Code:_____)
☐ Other_____ (_____)
☐ Rheumatoid Arthritis (ICD-10 Code:_____)

J Code: J0717

CIMZIA ORDERS

Initial dose: ☐ 400mg SubQ at weeks 0,2 and 4

Maintenance dose: ☐ 200mg SubQ every_____ weeks for_____ weeks
☐ 400mg SubQ every_____ weeks for_____ weeks

****Date of last** ☐ Remicade ☐ Orencia ☐ Humira ☐ CIMZIA dose:_____ Date:_____

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	