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**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: _____)
- Psoriatic Arthritis (ICD-10 Code: _____)
- Rheumatoid Arthritis (ICD-10 Code: _____)
- Ankylosing Spondylitis (ICD-10 Code: _____)
- Other _____ (_____)

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:	