Cimzia (CERTOLIZUMAB PEGOL)
Subcutaneous injection orders

REQUIRED INFORMATION

- o This order signed by provider
- o Patient demographics & insurance information
- o Clinical/Progress notes, labs, tests supporting primary diagnosis
- o TB test attached OR
- o Perform TB Testing
- o TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD
  - o Yearly TB screening (optional)
- o Hepatitis B Protocol: Hep B surface antigen & Hep B Core AB total required

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

Chron's Disease (ICD-10: _________________)
Psoriatic Arthritis (ICD-10: ________________)
Rheumatoid Arthritis (ICD-10: _____________)
Ankylosing Spondylitis (ICD-10: _____________)
Other: _____________________________

J Code: J0717

Initial dose: 400 mg SubQ at 0, 2, 4 weeks Maintenance dose: o 200 mg SubQ every ____ weeks for _____weeks o 400 mg SubQ every ____ weeks for _____ weeks Date of last (if applicable): o Remicade: Dose ______ Date_____ o Orencia: Dose _______ Date _____ o Humira: Dose________ Date _____ o Cimzia: Dose ________ Date_____
Additional instructions:

Physician Name:	Phone:	Fax:

Physician Signature:	Date: