Cimzia Subq (Certolizumab Pegol)
Referral Form

REQUIRED INFORMATION

☐ This signed order form from the providers
☐ Patient demographics and insurance information
☐ Clinical/Progress Notes, Labs (including results for TB QuantiFERON Gold, Hep B surface antigen, and Hep B Core antibody total), and Tests supporting primary diagnosis (ICD-10 below)
☐ Documentation of any tried and failed therapies

Patient Name:	DOB:	Weight:
Allergies:	Patient Phone:	

Diagnosis:

☐ Crohn's Disease (ICD-10 _____)
☐ Plaque Psoriasis (ICD-10 _____)
☐ Psoriatic Arthritis (ICD-10 _____)
☐ Rheumatoid Arthritis (ICD-10 _____)
☐ Ankylosing Spondylitis (ICD-10 _____)
☐ Other (ICD-10 _____)

Initial Dose: ☐ 400 mg subcutaneously at weeks 0, 2, and 4

Maintenance Dose: ☐ 200 mg subcutaneously every 2 weeks
☐ 400 mg subcutaneously every 4 weeks
☐ Other: _____

Refill: ☐ PRN x 1 year OR _____ times

Pre-Medication Orders (optional):

☐ Acetaminophen 650 mg OR ☐ Acetaminophen 1000 mg

☐ Diphenhydramine 25 mg OR ☐ Cetirizine 10 mg

☐ Other: _____

Required routine labs to be drawn by ☐ Infusion Center ☐ Referring Physician

Labs: _____ Frequency: _____

CBC, TB, and Hep B should be monitored at regular intervals while on therapy

Supply Orders: ☐ Pharmacy to provide all supplies needed to complete therapy as prescribed

Nursing Orders: ☐ Pharmacy to provide nursing services for initial administration and teaching and as needed
☐ May use Burnham's Vital Care anaphylaxis protocol as needed

Additional Instructions:

Practitioner Name:	Practitioner Signature:	Date:

Practitioner Address: