CIMZIA
(certolizumab pegol)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results
- Negative Hep B Panel

PRIMARY DIAGNOSIS

☐ K50.90 Crohn's disease, unspecified, without complications
☐ L40.0 Psoriasis vulgaris
☐ L40.50 Arthropathic psoriasis, unspecified
☐ M05.79 Rheumatoid arthritis with rheumatoid factor, w/o org/sys involvement
☐ M06.00 Rheumatoid arthritis without rheumatoid factor, unsp site
☐ M06.89 Other specified rheumatoid arthritis, multiple sites
☐ M06.9 Rheumatoid arthritis, unspecified
☐ Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Cimzia.
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

Crohn's Disease:
☐ Cimzia 400mg subQ injection at Week 0, 2, 4, and every 4 weeks thereafter

Rheumatoid Arthritis:
☐ Cimzia 400mg subQ injection at Week 0, 2, 4, and then 200mg subQ injection every other week thereafter

Psoriatic Arthritis:
☐ Cimzia 400mg subQ injection at Week 0, 2, 4, and then 200mg subQ injection every other week thereafter

Ankylosing Spondylitis:
☐ Cimzia 400mg subQ injection at Week 0, 2, 4, and then 200mg subQ injection every other week thereafter

Non-radiographic Axial Spondyloarthritis:
☐ Cimzia 400mg subQ injection at Week 0, 2, 4, and then 200mg subQ injection every other week thereafter

Plaque Psoriasis:
☐ Cimzia 400mg subQ injection every other week

☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted: _____

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____

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