

Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226



Prince George
2025B Waterside Rd
Prince George, VA 23875

Physician Order - Cimzia (certolizumab)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose/Frequency Change <input type="checkbox"/> Order Renewal

Location Preference (optional)
<input type="checkbox"/> Richmond <input type="checkbox"/> Prince George

** If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access **

DIAGNOSIS AND ICD 1-0 CODE	
<input type="checkbox"/> Crohn's Disease	K5090
<input type="checkbox"/> Rheumatoid Arthritis	M06.9
<input type="checkbox"/> Ankylosing Spondylitis	M45.9
<input type="checkbox"/> Arthropathic Psoriasis	L40.50
<input type="checkbox"/> Other: _____	ICD10 _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress Notes
<input type="checkbox"/> Patient Demographics AND Insurance Information	<input type="checkbox"/> Labs and Tests Supporting Primary Dx
<input type="checkbox"/> Hepatitis B Test Results: HBsAg	
<input type="checkbox"/> QuantiFERON Gold TB Test Results	
<input type="checkbox"/> Patient currently receiving same therapy at _____	Last dose: _____

List Tried & Failed Therapies, including duration of treatment

1) _____

2) _____

3) _____

MEDICATION ORDERS**	
Initial Dosing	<input type="checkbox"/> Cimzia 400mg administer sub q at week 0, 2, 4, then every 4 weeks
Maintenance	<input type="checkbox"/> Cimzia 400mg administer sub q every 4 weeks
	<input type="checkbox"/> Cimzia 200mg administer sub q every 2 weeks
Patient Weight = _____ kg	Patient Height = ____ ft ____ in
Duration: <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> doses _____	

**Patient weight is required for all weight based therapies - please indicate weight in kilograms.

PREMEDICATIONS
<input type="checkbox"/> Acetaminophen 650mg PO prior to Cimzia administration
<input type="checkbox"/> Diphenhydramine 25mg PO prior to Cimzia administration
<input type="checkbox"/> Methylprednisolone 40mg slow IVP
<input type="checkbox"/> Other: _____

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing.

PRESCRIBER INFORMATION			
Prescriber Name:	NPI:	Contact:	
Phone:	Fax:	Email:	
Prescriber Signature:	Date:		

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com

Fax completed form and ALL documentation to 804-554-5848

All information contained in this form is strictly confidential and will become part of the patient's record.