

Cimzia (Certolizumab)

Infusion Order Form – Page 1 of 1



Preferred Clinic Location

- ☐ **Harbor Health Park Bend Clinic**
2200 Park Bend Drive, Bldg 2, Suite 300, Austin, TX 78758
P: (855) 481-8375
F: (512) 233-2288

Patient Information

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: _____ Patient Name: _____ DOB: _____
ICD-10 code (required): _____ ICD-10 description: _____
☐ NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____
Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Provider Information

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list
- Clinicals to support one or more of the following:
 - Patient has moderately to severely active rheumatoid arthritis (RA)
 - Patient has active psoriatic arthritis
 - Patient has active ankylosing spondylitis
 - Patient has active moderately to severely Crohn's disease who has had an inadequate response to conventional therapy
 - Patient has moderate to severe plaque psoriasis (PSO) who is a candidate for systemic therapy or phototherapy
 - Patient has non-radiographic axial spondyloarthritis (nr-axSpA)

Orders

NURSING

- ☒ Nursing care per [Harbor Health Nursing Procedures](#) and [Harbor Health Adverse Reaction Management Protocol](#).
☒ TB status & date (list results here & attach clinicals)
☒ Hepatitis B status & date (list results here & attach clinicals)
☒ Verify no latex allergy if using the pre-filled syringe

PRE-MEDICATION

(Administer 30 minutes prior to procedure)

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____ Frequency: _____

THERAPY

- ☒ **Certolizumab (Cimzia)** subcutaneous injection
- Dose: ☐ 400mg ☐ _____mg at Week 0, 2, 4, and then with maintenance dosing below
 - Each 400mg dose should be given as two separate subcutaneous injections of 200 mg, and should occur at separate sites in the thigh or abdomen.
- ☐ Maintenance
- Dose: ☐ 200mg / ☐ 400mg
 - Frequency: ☐ every 2 weeks / ☐ every 4 weeks / ☐ other _____
- ☐ Patient is required to stay for 30-minute observation

Provider Name (Print): _____

Provider Signature: _____

Date: _____