# Cimzia (certolizumab pegol)

**Provider Order Form** *rev. 1/2/2025*

AMERICAN INFUSION CARE
SPECIALTY INFUSION

## PATIENT INFORMATION

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

Patient Full Name: _____ DOB:_____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

**Patient Status:** ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

**Patient Preferred Location:** _____

## DIAGNOSIS & CLINICAL INFORMATION

**ICD 10-Code & Description (**Provide full completed code)

- ☐ K50.0_____ Crohn's Disease, Small Intestine
- ☐ K50.1_____ Crohn's Disease, Large Intestine
- ☐ K50.8_____ Crohn's Disease, Small & Large Intestine
- ☐ K50.9_____ Crohn's Disease, Unspecified
- ☐ L40.0 Psoriasis Vulgaris (Plaque Psoriasis)
- ☐ L40.50 Arhtropathic Psoriasis
- ☐ L40.52 Psoriatic Arthritis
- ☐ L40.59 Other Psoriatic Arhtropathy
- ☐ L40.9 Psoriasis, Unspecified
- ☐ M05.0 _____Felty's Syndrome
- ☐ M05.9 _____ Rheumatoid Arthritis, w/Rheumatoid Factor
- ☐ M06.00 _____ Rheumatoid Arthritis, w/o Rheumatoid Factor
- ☐ M45. _____ Ankylosing Spondylitis
- ☐ Other: _____

**REQUIRED DOCUMENTATION:** Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results ( CBC, CMP, TB, Hep B panel-depending on medication) , signed prescription order and recent visit notes.
Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

## PRESCRIPTION INFORMATION

**Nursing:** Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

**Pre-Medications**

- ☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
- ☐ Cetirizine (Zyrtec) 10mgPO
- ☐ Loratadine (Claritin) 10mgPO
- ☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
- ☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
- ☐ Other: _____ Dose: _____ Route: _____

**Lab Orders**

*Required:* Negative TB, annually & Negative Hep B within 3 years

☐ Other: _____

**CIMZIA (certolizumab pegol)** (Select one):

**Loading Dose:**

☐ **SubQ:** Inject 400 mg at weeks 0, 2, and 4

**Maintenance Dose:**

- ☐ **SubQ:** Inject 200 mg every 2 weeks for one year
- ☐ **SubQ:** Inject 400 mg every 4 weeks for one year
- ☐ **SubQ:** Inject _____ mg every _____ weeks

**Is the patient on any other disease modifying therapy? ☐ Yes ☐ No If yes, please note therapy and last dose:**_____

**Post Treatment Observations:** The patient is required to stay for 30 minutes following the first administration.
**Special Instructions:** _____

☐ **Refills:** ☐ zero ☐ 6 months ☐ 12 months ☐ _____ *(Prescription valid for one year, unless otherwise indicated)*

## PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

_____ _____ _____
*Provider Name (Print)* *Provider Signature* *Date*

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McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454