(certolizumab pegol)

CIMZIA infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Rheumatoid Arthritis
- ☐ _____ Crohn's Disease
- ☐ _____ Ankylosing Spondylitis
- ☐ _____ Psoriatic Arthritis
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

CIMZIA ORDERS

DOSAGE/FREQUENCY

- ☐ 400mg SQ initially and at Weeks 2 and 4 *(induction)*
- ○ 200mg SQ every 2 weeks
- ○ 400mg SQ every 4 weeks *(maintenance)*

PATIENT WEIGHT

_____ lbs.

_____ kg

TB TESTING

- ○ Perform Quantiferon Gold (QFT Gold)
- ○ Perform PPD Skin Test

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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