FLOMED INFUSION

6274 Linton Blvd. Suite 105 | Delray Beach, FL 33484
T: 561-559-9800 F: 561-559-9801
flomedinfusion.com

CIMZIA (certolizumab pegol)

PATIENT INFORMATION

Patient Name:_____ Date of Birth: _____ Phone: _____
Status: ☐ New to therapy ☐ Continuing ☐ Next Due Date (if applicable)

PROVIDER INFORMATION

Provider Name:_____ Provider NPI: _____

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

Practice Name: _____

Practice Phone: _____ Fax: _____ Contact Person: _____

MEDICAL INFORMATION

Patient Weight: _____ Patient Height: _____ ICD-10 Code (required): _____ ICD-10 Description: _____

Known Allergies: _____

Required Labs: TB (QFT or PDD), Hep B surface antigen and Hrp B core AB total

DETAILS NEEDED FOR AUTHORIZATION

- Proof of patient's negative latent TB test. If test is positive, proof that patient has begun therapy for latent TB.
- Proof of patient being concurrently treated with any other biologic: _____
- Has the patient tried another biologic immunomodulator agent that is FDA labeled for this condition? _____
- If the patient is taking another TNF, IL-1 inhibitor, or non-biologic such as infliximab, etanercept or ankinra, will it be stopped? _____

CIMZIA (certolizumab pegol) ORDERS

Crohn's Disease
☐ Initial Dose: 400mg subcutaneously at weeks 0, 2, and 4 weeks
Maintenance Dose: ☐ 400mg subcutaneously every 4 weeks

Psoriasis
☐ 400mg subcutaneously every 2 weeks
☐ 200mg subcutaneously every 2 weeks
☐ 400mg subcutaneously at weeks 0, 2, and 4 weeks

RA/Psoriatic Arthritis/Anklosing Spondylitis/Spondyloarthritis
☐ Initial Dose: 400mg subcutaneously at weeks 0, 2, and 4 weeks
Maintenance Dose: ☐ 200mg subcutaneously every 4 weeks
☐ 400mg subcutaneously every 4 weeks

Additional Orders/Comments: _____

_____

ADULT RESCUE MANAGEMENT PROTOCOL

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Following standing reaction orders, including diphenhydramine, methylprednisolone, albuterol, and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

REQUIRED STANDARD DOCUMENTATION NEEDED

- Patient demographics
- Patient medical insurance card, copied front and back
- Patient pharmacy card, copied front and back (if they have one)
- Most recent chart notes and if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

PROVIDER AUTHORIZATION

Provider's Signature: _____ Print Name: _____ Date: _____