Certolizumab (Cimzia)

Provider Order Form rev. 7/30/2025

PATIENT INFORMATION

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

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

RA w/rheumatoid factor, multiple sites: RA w/o rheumatoid factor, multiple sites:

Rheumatoid arthritis of unspecified site with involvement of organs and systems:

Arthropathic psoriasis, unspecified: Other psoriatic arthropathy:

Ankylosing spondylitis of unspec sites in spine: Ankylosing spondylitis of multiple sites in spine:

psoriatic vulgaris (plaque psoriasis): other psoriasis: psoriasis, unspecified:

Other: Description:

THERAPY ADMINISTRATION & DOSING

☐ Induction: Cimzia 400mg (2 sub-q 200mg injections) On week 0, week 2 and week 4

☐ Maintenance: Cimzia 200mg

☐ Maintenance: Cimzia 400mg

☑ Following initial Cimzia treatment, observe patient for 15 minutes for hypersensitivity.

MAINTENANCE DOSE FREQUENCY *(Choose one)*

☐ Maintenance: every 2 weeks

☐ Maintenance: every 4 weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☐ CBC w/diff, CMP, ESR, CRP every 8 weeks

☐ QuantiFERON TB Gold once per year; target collection date: _____

☐ Other: _____

PRE-MEDICATION ORDERS

☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Signs or symptoms of illness/active infection or cough, night sweats, weight loss or neurological changes
- HBV positive carrier (contraindicated) or signs or symptoms of HBV
- Planned/recent surgical procedures or recent live vaccinations

☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, colonoscopy (by indication)

Required Labs: Negative TB within 12 months, Negative Hep B, CRP, ESR. For RA: Rheumatoid factor, CCP, For CD/UC: Fecal Calpro

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.

Disclaimer: By signing this form, I authorize Novella Infusion and its affiliates to act as my designated agent in submitting prior authorizations, financial assistance applications, and other clinically required information with respect to this patient and order. This enrollment form shall serve as my signature for prior authorizations and financial assistance programs, as requested.