ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER	
ALLERGIES/REACTIONS (REQUIRED):	Yakima Outpatient Infusion Care 808 N 39th Ave Yakima WA 98902 Phone: 509-575-1174 Fax: 509-577-5021
ORDERS WITH CHECK BOXES	**When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.**
CODE STATUS	Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders.

CERTOLIZUMAB PEGOL (CIMZIA)

Patient Name:_____ Requested Start Date: _____/_____/_____
Date of Birth:_____/_____/_____ Patient Weight: _____ kg

***DIAGNOSIS & ICD-10 CODE*:**
❑ Crohn's Disease (ICD-10: _____) ❑Plaque Psoriasis (ICD-10: _____) ❑ Ankylosing spondylitis (ICD-10: _____)
❑ Rheumatoid Arthritis (ICD-10: _____) ❑ Psoriatic Arthritis (ICD-10: _____) ❑ Other (ICD-10: _____)

***REQUIRED*:** H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available

REQUIRED BASELINE LABS & INFORMATION:
- ✓ Rationale/reason for patient not being able to self-administer medication: _____
- ✓ CBC & CMP
- ✓ Negative Latent TB Test (Date: _____ | ❑ QuantiFERON Gold | ❑ PPD | ❑ Chest X-Ray | ❑ Other: _____)
- ✓ HBV Screening/Status (Date: _____ | HepBsAg _____ | HepBsAb _____ | HepB Core Ab _____)

ROUTINE LABS: ❑ CMP | ❑ CBC w/ diff | ❑ LFT | ❑ CRP | ❑ Trough | ❑ ESR | ❑ Other: _____
ROUTINE LAB FREQUENCY: ❑ Each Injection | ❑ Annually | ❑ Other: _____

CERTOLIZUMAB PEGOL (CIMZIA) SUBCUTANEOUS INJECTION **Please note dosing options below and complete this section in its entirety**

- **Crohn's Disease Regimen**
  - ❑ Induction/Initial: 400 mg SQ at weeks 0, 2, and 4 then 400 mg every 4 weeks thereafter
  - ❑ Maintenance/Continuation: 400 mg SQ every 4 weeks
- **Plaque Psoriasis Regimen** **variable dosage options shown below**
  - ❑ 400 mg SQ every other week OR
  - ❑ ≤ 90 kg Induction/Initial: 400 mg SQ at weeks 0, 2, and 4 **then** 200 mg every other week
  - ❑ ≤ 90 kg Maintenance: 200 mg SQ every other week
- **Ankylosing Spondylitis Regimen** **variable dosage options shown below**
  - ❑ Induction/Initial: 400 mg SQ at weeks 0, 2, and 4 **then** ❑ 200 mg every 2 weeks **or** ❑ 400 mg every 4 weeks
  - ❑ Maintenance/Continuation: ❑ 200 mg SQ every 2 weeks **or** ❑ 400 mg SQ every 4 weeks
- **Rheumatoid & Psoriatic Arthritis Regimen** **variable dosage options shown below**
  - ❑ Induction/Initial: 400 mg SQ at weeks 0, 2, and 4 **then** ❑ 200 mg SQ every other week **or** ❑ 400 mg SQ every 4 weeks
  - ❑ Maintenance/Continuation: ❑ 200 mg SQ every other week **or** ❑ 400 mg SQ every 4 weeks

***SUPPORTIVE CARE*:** Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

***DISCHARGE*:** 30 minutes after injection is complete when vital signs are stable and hypersensitivity symptoms are absent. Waiting period can be waived by patient on subsequent injections.

Provider Signature: _____ Date: _____
Print name: _____ Phone # _____ Fax # _____

❑ NEW REFERRAL ❑ UPDATED REFERRAL ****Expires 12 months from written date****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

CERTOLIZUMAB PEGOL (CIMZIA)

MultiCare

Yakima Memorial Hospital