**ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN**

**Allergies/Reactions:**

Fax all infusions to: 833-380-8800
Please mark the appropriate infusion center:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge Infusion Center

**ORDERS WITH CHECK BOXES** When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

## Certolizumab Pegol (Cimzia):

Patient Name:___________________________________________________ Requested Date of Service: ________ /________ /________

Date of Birth: ______ /______ /_______ Patient Phone Number: ( ______ ) ________ - ___________________ ❑ May leave message

**Diagnosis:**

| Diagnosis | ICD -10 Code: |
|---|---|
| ❑ Ankylosing Spondylitis, active (AS) | ❑___________________________________ |
| ❑ Crohn's disease, active (CD) | ❑___________________________________ |
| ❑ Non-Radiographic Axial Spondyloarthritis (NRAS) | ❑___________________________________ |
| ❑ Plaque Psoriasis (PPs) | ❑___________________________________ |
| ❑ Psoriatic Arthritis, active (PsA) | ❑___________________________________ |
| ❑ Rheumatoid Arthritis, active (RA) | ❑___________________________________ |
| ❑ Other_________________________ | ❑___________________________________ |

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

☑ **Reason patient not able to self-administer medication:** ____________________________________________________________

**Baseline Labs Required:**

- CBC / CMP
- Latent TB testing Date: ______/______/______ Results: _____________________
- HBV screening Date: ______/______/______ Results: _____________________
- HCV screening Date: ______/______/______ Results: _____________________
- HIV screening Date: ______/______/______ Results: _____________________

**Maintenance labs required:**

- Annual Latent TB testing
- CBC every 6 months

Contact provider if patient develops serious infection; close monitoring by provider is recommended. Follow-up appointment with referring provider scheduled for (date): ______/______/______

**Treatment Regimens:**

- ❑ **AS/NRAS:** Initial: 400 mg SQ at weeks 0, 2, and 4; Maintenance: 200 mg every 2 weeks or 400 mg every 4 weeks
- ❑ **CD:** Initial: 400 mg SQ at weeks 0, 2, and 4; Maintenance: 400 mg every 4 weeks
- ❑ **PsA/RA:** 400 mg SQ at weeks 0, 2, and 4 **THEN** ❑ 200 mg SQ every other week **OR** ❑ 400 mg SQ every 4 weeks
- ❑ **PPs:** ❑ 400 mg SQ every other week **OR** ❑ $\leq$90 kg; 400 mg SQ at weeks 0, 2, 4 then 200 mg every other weeks

☑ **Vital signs:** Check vital signs prior to and at completion of dose.
Contact provider if systolic BP>180; diastolic BP>100; systolic BP<90; HR >110; temp >38C (100.4F)

**If Hypersensitivity reaction (fever, chills, hypotension, rigors, itching, rash, etc.)**

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

**Code Status: Please note, 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.**

**Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)**

| ________________________ | ________________________ | ____________ | ____________ |
|---|---|---|---|
| Provider Signature | Print Name | Date | Time |

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expires in 12 months****

**Patient Identification - Always Attach Patient Label**

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
**CERTOLIZUMAB PEGOL (Cimzia)**

61-0104-4 (Rev. 9/24)