SPECIALTY INFUSION CENTER
An Access Infusion Care Company

CIMZIA (CERTOLIZUMAB) ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ Phone: _____ Allergies: _____

City, State, Zip: _____ Email: _____

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD 10-CODE

☐ Ankylosing Spondylitis	ICD-10 Code: _____
☐ Axial Spondyloarthritis	ICD-10 Code: _____
☐ Psoriatic Arthritis	ICD-10 Code: _____
☐ Plaque Psoriasis	ICD-10 Code: _____
☐ Crohn's Disease	ICD-10 Code: _____
☐ Rheumatoid Arthritis	ICD-10 Code: _____
☐ Other: _____	ICD-10 Code: _____

Has the patient had failure or contraindication to at least 12 weeks of at least one DMARD? ☐ YES ☐ NO

REQUIRED DOCUMENTATION

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ Hepatitis B Test Results: HBsAg, Total HepB Core Antibody

☐ H&P and Clinical/Progress notes supporting primary diagnosis

☐ Labs and Tests supporting primary diagnosis

☐ TB Test Results

List Tried & Failed Therapies, including duration of treatment:

1)

2)

MEDICATION ORDERS

Crohn's Disease	☐ Initial Dose: Cimzia 400mg subQ at weeks 0, 2, and 4 weeks followed by: ☐ Cimzia 400mg subQ every 4 weeks
RA/Psoriatic Arthritis/Ankylosing Spondylitis/Spondyloarthritis	☐ Initial Dose: Cimzia 400mg subQ at weeks 0, 2, and 4 weeks followed by: ☐ Cimzia 200mg subQ every 2 weeks ☐ Cimzia 400mg subQ every 4 weeks
Psoriasis	☐ Cimzia 400mg subQ every 2 weeks ☐ Cimzia 400mg subQ at weeks 0, 2, and 4 followed by 200mg subQ every 2 weeks ☐ Cimzia 200mg subQ every 2 weeks

Refills: ☐ X 6 months ☐ X 1 Year ☐ _____doses

☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

☐ RN to flush and lock VAD/CVAD per company protocol

Other: _____

EMERGENCY MEDICATIONS

☐ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

REV: 6/2025

Gaylord, MI
Phone: (989) 619-6253
Fax: (855) 857-3834

Traverse City, MI
Phone: (231) 252-0893
Fax: (855) 857-3834

Marquette, MI
Phone: (906) 661-1088
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