SPECIALTY INFUSION CENTER
An Access Infusion Care Company

CERTOLIZUMAB ORDERS (Cimzia)

CENTERS AT SIC
An Access Infusion Care Managed Company

REFERRAL CHECKLIST
Please make sure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ CBC w/diff/CMP/CRP/TB and Hep B screening results
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (855) 857-3834

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ **New Referral** ☐ **Continuation Order** ☐ **Dose or Frequency Change**

First dose? ☐ Yes ☐ No - Date of last injection:

DIAGNOSIS

☐ Dx code/description:

REQUIRED DOCUMENTATION ☐ **Signed order** ☐ **Demographics/insurance info** ☐ **H&P/labs/tests/progress notes supporting the Dx**

Prior Therapies:

☐ Hepatitis B Screening: ☐ Positive ☐ Negative-Date:	☐ TB Screening: ☐ Positive ☐ Negative-Date:

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐ CMP ☐ CBC w dif ☐ CRP ☐ Sed Rate ☐

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☒ **Certolizumab (Cimzia)**	200mg/mL	**CD dosing** ☐ Induction: 400mg subQ at weeks 0, 2, and 4 weeks, then ☐ Maintenance: 400mg subQ every 4 weeks	☒ # vials sufficient for dose Refills:
		RA/PsA/PsO/SA dosing ☐ Induction: 400mg subQ at weeks 0, 2, and 4 weeks, then ☐ Maintenance: ☐ 200mg subQ every 2 weeks ☐ 400mg subQ every 4 weeks	
		Plaque Psoriasis dosing ☐ 400mg subQ every 2 weeks ☐ Patients≤90kg-Induction: 400mg subQ at weeks 0, 2, and 4 weeks, then ☐ Patients≤90kg-Maintenance: 200mg subQ every 2 weeks	

If not specified, order will be valid for 1 year from the date of signature.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/5mLHeparin 100u/mL(Port)final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mLIV over 30-60 min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mLIV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain $SpO_2$95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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