Ascension St. Vincent's Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Certolizumab pegol (Cimzia®) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List: _____

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐ Rheumatoid Arthritis with Rheumatoid Factor, Multiple Sites	☐ M05.79	☑ Ex. J0717	☑ CPT Code: _____
☐ Rheumatoid Arthritis without Rheumatoid Factor, Multiple Sites	☐ M06.09		
☐ Ankylosing Spondylitis of Unspecified Sites in Spine	☐ M45.9		
☐ Ankylosing Spondylitis of Multiple Sites in Spine	☐ M45.0		
☐ Axial Spondyloarthritis, Non-radiographic	☐ M45.A6		
☐ Plaque Psoriasis	☐ L40.0		
☐ Psoriatic Arthritis	☐ L40.52		
☐ Crohn's Disease	☐ K50.90		
☐ Other: _____	☐ Other: _____		

Labs (prior to scheduling initial infusion)	Other labs:
☑ CBC w/diff, CMP, CRP, ESR, Hepatitis Panel, TB Test	☐ _____ ☐ _____

Nursing Orders	Pre-medications (not required)	
☑ Discharge patient when stable and meets protocol criteria	☐ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
Emergency/Anaphylaxis Order	☐ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☑ Follow standard orders for management of allergies and anaphylaxis reactions	☐ Dexamethasone 20 mg IV, once	☐ Other: _____
	☐ Ondansetron 4 mg IV, once	☐ Other: _____

Medication Orders

	Medication	Route	Select Treatment Type
☑	Certolizumab (Cimzia)	SQ	☐ Initial: 400 mg (via 2 separate 200 mg injections) at weeks 0, 2, and 4 ☐ Maintenance: 200 mg every 2 weeks via 1 single 200 mg injection for _____ doses ☐ Maintenance: 400 mg every 4 weeks via 2 separate 200 mg injections for _____ doses ☐ 400 mg every 2 weeks via 2 separate 200 mg injections (Plaque Psoriasis ONLY) for ___ ____ doses ☐ Other: _____

Infusion Center Staff Please fax infusion records or discharge summary to: **Fax Number** _____

Provider Signature		**Date**	
Provider Printed Name			