Nevada Infusion
5401 Longley Lane, Suite 34, Reno, NV 89511
PH: 775-453-0667 | Fax: 775-470-8478

Cimzia Order Form

Patient Name: _____ DOB:_____
Phone:_____ Address: _____
City: _____ State:_____ Zip:_____ Email: _____
Sex: _____ Height: _____ Weight:_____ Allergies:_____

DIAGNOSIS:

- ☐ Crohn's Disease ICD-10:_____
- ☐ Psoriatic Arthritis ICD-10:_____
- ☐ Rheumatoid Arthritis ICD-10:_____
- ☐ Plaque Psoriasis ICD-10:_____
- ☐ Non-radiographic Axial Spondyloarthritis ICD-10:_____
- ☐ Ankylosing Spondylitis ICD-10:_____
- ☐ Other_____ICD-10:_____

ORDER FOR CIMZIA (CERTOLIZUMAB PEGOL):

☐ **Initial:** 400mg subQ at weeks 0, 2, and 4 weeks followed by 400mg subQ every 4 weeks x1 year
☐ **Initial:** 400mg subQ at weeks 0, 2, and 4 weeks followed by 200mg subQ every 2 weeks x1 year
☐ **Maintenance**: 200mg subQ every 2 weeks x1 year
☐ **Maintenance**: 400mg subQ every 4 weeks x1 year
☐ **Maintenance:** 400mg subQ every 2 weeks x1 year

PRE-MEDICATIONS:

- ☐ Acetaminophen 650mg PO
- ☐ Diphenhydramine 25mg PO or IV or Zyrtec 10 mg PO
- ☐ Hydrocortisone 100mg IV or Methylprednisolone 125mg IV
- ☐ Additional Pre-Medications: _____

MAY ADMINISTER IF NEEDED FOR ALLERGIC REACTION:

- ☑ **Nevada Infusion Hypersensitivity Reaction Order Set**
- ☐ Other: _____

ACCESS: Peripheral IV, Port, Midline, or PICC line
FLUSHING: 10 mls NS pre/post infusion OR Heparin 5ml for port – 100 units/ml
NURSING: Per Nevada Infusion

LABS ORDERS: _____ Fax results to: _____

PROVIDER INFORMATION:

Physician Name: _____ NPI:_____
Physician Signature: _____ Date:_____
Point of Contact: _____ Phone:_____ Email: _____

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **

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Patient Name: _____ DOB:_____

Please Include Required Documentation for Expedited Order Processing & Insurance Approval:

☐ Signed provider orders (page 1)
☐ Patient demographic and insurance information
☐ Patient's current medication list
☐ Supporting recent clinical notes and H&P (to support primary diagnosis)
☐ Supporting documentation to include past tried and/or failed therapies

☐ Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, steroids, or conventional therapy (i.e., MTX, 6-MP, leflunomide)?
☐ Yes OR ☐ No
If yes, which drug(s)? _____
☐ Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Enbrel, Stelara)?
☐ Yes OR ☐ No
If yes, which drug(s)? _____

☐ If psoriasis diagnosis, percent of body surface (BSA) involved: _____ %

☐ Include labs and/or test results to support diagnosis

☐ If applicable - Last known biological therapy: _____ and last date received: _____

If the patient is switching to biologic therapies, please perform a wash-out period of _____ weeks prior to starting Cimzia.

☐ Other medical necessity documentation (please include): _____

Additional REQUIRED Information
☐ TB screening test completed within 12 months - please include results
☐ Positive OR ☐ Negative
☐ Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) - please include results
☐ Positive OR ☐ Negative

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Revised 04/25