Patient Name:
DOB:
Date of Last Infusion
Insurance:

Clinic Location:
Merrimack, NH ☐
Concord, NH ☐

# Cimzia® (certolizumab pegol) Treatment Orders

| Diagnosis: | |
|---|---|
| ☐M05.79 RA w/rheumatoid factor, multiple sites | ☐ M06.09 RA w/o rheumatoid factor, multiple sites |
| ☐ M05.60 Rheumatoid arthritis of unspecified site with involvement of organs and systems | ☐ M05.70 Rheumatoid arthritis with rheumatoid factor of unspec site w/o organ or systems involvement |
| ☐ L40.50 Arthropathic psoriasis, unspecified | ☐ L40.59 Other psoriatic arthropathy |
| ☐ M45.9 Ankylosing spondylitis of unspec sites in spine | ☐ M45.0 - Ankylosing spondylitis of multiple sites in spine |
| ☐ L40.0 psoriatic vulgaris (plaque psoriasis) ☐L40.8 other psoriasis | ☐ L40.9 psoriasis, unspecified |
| Other: ______________________________ (ICD-10 and description) | |

## Nursing Orders:

☑ Hold treatment and notify provider for:

- Signs or symptoms of illness or active infection
- Cough, night sweats, unexplained weight loss
- Planned/recent surgical procedures
- Neurological changes
- Recent live vaccinations

## Lab Orders:

☐ CBC w/diff, CMP, ESR, CRP every 8 weeks

☐ Quantiferon TB Gold once per year; target collection date:___________________

☐ Other: ______________________________________________________________

## Initial Dosing

On Week 0, Week 2 and Week 4 administer **Cimzia 400 mg** (given as 2 subcutaneous injections of 200 mg).

## Maintenance Dosing

Administer **Cimzia** ☐ **200 mg** ☐ **400 mg** (given as 2 subcutaneous injections of 200 mg).

**Frequency:** ☐Repeat every 2 weeks ☐Repeat every 4 weeks

## Observation Period:

☑ Following *initial* Cimzia treatment, observe patient for 15 minutes for hypersensitivity. Patients who have previously tolerated Cimzia do not require observation period.

☑ If hypersensitivity reaction occurs, initiate Hypersensitivity Reaction Management Policy/Protocol as clinically indicated.

Ordering Provider: (please print):________________________________________________________

Provider signature: ____________________________________________ Date: ____________________

Revised 9/11/19. Order valid for one year unless otherwise indicated.