ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Gig Harbor Infusion Services - Fax: 253-530-8069
❑ Allenmore Ambulatory Infusion Services - Fax: 253-864-4052
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ Auburn Infusion Services - Fax: 253-876-8282
❑ North Spokane Infusion Center - Fax: 509-232-2531

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Certolizumab Pegol (Cimzia):

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis:		**ICD -10 Code:**
	❑ Ankylosing Spondylitis, active (AS)	❑_____
	❑ Crohn's disease, active (CD)	❑_____
	❑ Non-Radiographic Axial Spondyloarthritis (NRAS)	❑_____
	❑ Plaque Psoriasis (PPs)	❑_____
	❑ Psoriatic Arthritis, active (PsA)	❑_____
	❑ Rheumatoid Arthritis, active (RA)	❑_____
	❑ Other_____	❑_____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

☑ **Reason patient not able to self-administer medication:** _____

Baseline Labs Required:

- CBC / CMP
- Latent TB testing Date: _____/_____/_____ Results: _____
- HBV screening Date: _____/_____/_____ Results: _____
- HCV screening Date: _____/_____/_____ Results: _____
- HIV screening Date: _____/_____/_____ Results: _____

Maintenance labs required:

- Annual Latent TB testing
- CBC every 6 months

Contact provider if patient develops serious infection; close monitoring by provider is recommended. Follow-up appointment with referring provider scheduled for (date): _____/_____/_____

Treatment Regimens:

❑ **AS/NRAS:** Initial: 400 mg SQ at weeks 0, 2, and 4; Maintenance: 200 mg every 2 weeks or 400 mg every 4 weeks
❑ **CD:** Initial: 400 mg SQ at weeks 0, 2, and 4; Maintenance: 400 mg every 4 weeks
❑ **PsA/RA:** 400 mg SQ at weeks 0, 2, and 4 **THEN** ❑ 200 mg SQ every other week **OR** ❑ 400 mg SQ every 4 weeks
❑ **PPs:** ❑ 400 mg SQ every other week **OR** ❑ ≤90 kg; 400 mg SQ at weeks 0, 2, 4 then 200 mg every other weeks

☑ **Vital signs:** Check vital signs prior to and at completion of dose.
Contact provider if systolic BP>180; diastolic BP>100; systolic BP<90; HR >110; temp >38C (100.4F)

If Hypersensitivity reaction (fever, chills, hypotension, rigors, itching, rash, etc.)

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time
_____	_____	_____	_____

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
CERTOLIZUMAB PEGOL (Cimzia)

MultiCare

61-0104-4 (Rev. 1/22)