Certolizumab (Cimzia)

Provider Order Form *rev. 11/06/26*

arbor infusion

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Mobile Phone Number:

Weight (lbs/kg): ☐ NKDA Allergies:

Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

REQUIRED SUPPORTING DOCUMENTATION *(Please include the following with the order to support processing & insurance approval)*

• Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)

• TB results: If TB results are positive, provide documentation of treatment or medical clearance, and a negative CXR

• Hepatitis B results: If Hepatitis B results are positive, provide documentation of medical clearance • Patient's current weight and height

DIAGNOSIS ICD-10 CODE *(Provider must specify)*

☐ K50.90 Crohn's disease, unspecified, without complications ☐ L40.0 Psoriasis vulgaris ☐ L40.50 Arthropathic psoriasis, unspecified

☐ M05.79 Rheumatoid arthritis with rheumatoid factor, w/o org/sys involvement ☐ M06.00 Rheumatoid arthritis without rheumatoid factor, unsp site

☐ M06.89 Other specified rheumatoid arthritis, multiple sites ☐ M06.9 Rheumatoid arthritis, unspecified

☐ Other:

PRIMARY MEDICATION ORDER

Certolizumab (Cimzia) subcutaneous injection

☐ Patient is required to stay for 30-minute observation

• Refill for 12 months unless otherwise noted: _____

☐ ***New Start:*** Administer ☐ 400mg ☐ _____mg at week 0, 2, 4, and maintenance of _____mg every _____ weeks

☐ ***Maintenance:*** Administer ☐ 200mg ☐ 400mg every ☐ 2 weeks ☐ 4 weeks ☐ Other: _____

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Cimzia

☐ acetaminophen (Tylenol) ☐500mg / ☐650mg / ☐1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ famotidine (Pepcid) 20 mg IV

☐ diphenhydramine (Benadryl) ☐25mg / ☐50mg ☐PO / ☐IV

☐ methylprednisolone (Solu-Medrol) ☐40mg / ☐125mg IV

☐ Other: _____

Dose: _____ Route: _____

NURSING

• Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print) **Provider Signature** **Provider NPI** **Date**

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zipcode:

ARBOR INFUSION FAX NUMBERS *(Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)*

☐ Arbor Infusion Fishers (317) 981-1772

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