

# Certolizumab (Cimzia)

Provider Order Form rev. 8/24/26



## 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 at week 0, 2, 4, and maintenance of ☐ \_\_\_\_\_mg every \_\_\_\_\_mg weeks

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

## 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)

## SPECIAL INSTRUCTIONS

## 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](mailto:orders@arborinfusion.com))

☐ Arbor Infusion Fishers (317) 981-1772