

**PATIENT INFORMATION**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Allergies: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_ Email: \_\_\_\_\_

**REFERRAL STATUS**

New Referral       Dose or Frequency Change       Order Renewal

Is this the first dose?  Yes  No, date of last infusion: \_\_\_\_\_ Line type:  PIV  PICC  Port  Other

**DIAGNOSIS AND ICD 10-CODE**

<input type="checkbox"/> Ankylosing Spondylitis	ICD-10 Code: _____
<input type="checkbox"/> Axial Spondyloarthritis	ICD-10 Code: _____
<input type="checkbox"/> Psoriatic Arthritis	ICD-10 Code: _____
<input type="checkbox"/> Plaque Psoriasis	ICD-10 Code: _____
<input type="checkbox"/> Crohn's Disease	ICD-10 Code: _____
<input type="checkbox"/> Rheumatoid Arthritis	ICD-10 Code: _____
<input type="checkbox"/> Other: _____	ICD-10 Code: _____

Has the patient had failure or contraindication to at least 12 weeks of at least one DMARD?  YES  NO

**REQUIRED DOCUMENTATION**

<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> H&P and Clinical/Progress notes supporting primary diagnosis
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Hepatitis B Test Results: HBsAg, Total HepB Core Antibody	<input type="checkbox"/> TB Test Results

List Tried & Failed Therapies, including duration of treatment:

1) \_\_\_\_\_

2) \_\_\_\_\_

**MEDICATION ORDERS**

Crohn's Disease	<input type="checkbox"/> Initial Dose: Cimzia 400mg subQ at weeks 0, 2, and 4 weeks followed by: <input type="checkbox"/> Cimzia 400mg subQ every 4 weeks
RA/Psoriatic Arthritis/Ankylosing Spondylitis/Spondyloarthritis	<input type="checkbox"/> Initial Dose: Cimzia 400mg subQ at weeks 0, 2, and 4 weeks followed by: <input type="checkbox"/> Cimzia 200mg subQ every 2 weeks <input type="checkbox"/> Cimzia 400mg subQ every 4 weeks
Psoriasis	<input type="checkbox"/> Cimzia 400mg subQ every 2 weeks <input type="checkbox"/> Cimzia 400mg subQ at weeks 0, 2, and 4 followed by 200mg subQ every 2 weeks <input type="checkbox"/> Cimzia 200mg subQ every 2 weeks

Refills:  X 6 months       X 1 Year       \_\_\_\_\_ doses

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

RN to flush and lock VAD/CVAD per company protocol

Other: \_\_\_\_\_

**EMERGENCY MEDICATIONS**

Administer the following medications as needed for infusion-related reactions per company protocol:

<b>Adults (weight &gt;40kg):</b> Diphenhydramine 25mg-50mg PO Diphenhydramine 25mg-50mg slow IV push over 2-5 mins Acetaminophen 325mg-650mg PO Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated Epinephrine 0.3mg IM/SQ, may repeat x1 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)	<b>Pediatrics (weight &lt;40kg): (may adjust with weight changes)</b> Diphenhydramine 25mg PO Diphenhydramine 25mg slow IV push over 2-5 mins Acetaminophen 325mg PO Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive
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**PRESCRIBER INFORMATION**

Prescriber Name: \_\_\_\_\_ NPI Number: \_\_\_\_\_  
 Office Phone: \_\_\_\_\_ Office Fax: \_\_\_\_\_  
 Prescriber Signature: \_\_\_\_\_ Date: \_\_\_\_\_