Vermont
28 Park Ave
Suite #1A
Williston, VT 05495

ThrIVewell™ INFUSION
Office: 212-803-3339 Fax : 646-768-8600

Mission Medical

(certolizumab pegol)

CIMZIA infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:	
Ordering Provider:	Provider NPI:	
Referring Practice Name:	Phone:	Fax:
Practice Address:	City: State:	Zip Code:

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Rheumatoid Arthriris
- ☐ _____ Crohn's Disease
- ☐ _____ Ankylosing Spondlitis
- ☐ _____ Psoriatic Arthritis
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

CIMZIA ORDERS

PATIENT WEIGHT

_____ lbs.

_____ kg

DOSAGE/FREQUENCY:

- ☐ 400mg SQ initially and at Weeks 2 and 4 *(induction)*
- ☐ 200mg SQ every 2 weeks *(maintenance)*
- ☐ 400mg SQ every 4 weeks

TB TESTING

- ☐ Perform Quantiferon Gold (QFT Gold)
- ☐ Perform PPD Skin Test

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____