*Fairfield*
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

*Greenwich*
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830

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 _____