

(certolizumab pegol)

# CIMZIA infusion orders

Patient Name

DOB

Phone

M

F

**DIAGNOSIS** *Please provide ICD-10 code*

Rheumatoid Arthritis

Psoriatic Arthritis

Crohn's Disease

*(other)*

Ankylosing Spondylitis

**PRE-MEDICATION**

Tylenol 1000mg PO

Solu-Medrol 125mg IVP

Diphenhydramine 25mg PO

Solu-Cortef 100mg IVP

Cetirizine 10mg PO

Diphenhydramine 25mg IVP

*(other)*

*(other)*

**CIMZIA ORDERS**

DOSAGE/FREQUENCY	PATIENT WEIGHT
400mg SQ initially and at Weeks 2 and 4 <i>(induction)</i>	lbs.
200mg SQ every 2 weeks	kg
400mg SQ every 4 weeks <i>(maintenance)</i>	
<b>TB TESTING</b>	
Perform Quantiferon Gold (QFT Gold)	
Perform PPD Skin Test	

**NOTES**

**ORDERING PROVIDER**

Signature X \_\_\_\_\_

Date

Provider

Phone

Fax