Agile Infusion Services LLC
Web: www.AgileIV.com | Tel: (201) 751-2202 | Fax: (201) 266-0437 | Email: info@AgileIV.com

CIMZIA MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ DOB _____

Patient's height in feet and inches _____ *Patient's weight in pounds*_____

■ **Diagnosis** *Diagnosis codes with blanks require the complete ICD-10 code, with all possible digits after the decimal.*

☐ M06.0 Rheumatoid arthritis w/o rheumatoid factor
☐ M06.8 Rheumatoid arthritis, other
☐ M40.0 Psoriasis vulgaris
☐ M45._____ Ankylosing spondylitis
☐ M40.52 Psoriatic arthritis mutilans
☐ K50.9_____ Crohn's disease

■ **Details Needed for Approval**

- Proof of patient's negative latent TB test. If test is positive, proof that patient has begun therapy for latent TB.
- Is patient concurrently being treated with any other biologic? _____
- Does the patient have an intolerance, contraindication or hypersensitivity to any of the following agents, or has tried and failed on at least one with at least 3 months of therapy? *If yes, circle all that apply.* They are: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, mesalamine, methotrexate, sulfasalazine, hydroxychloroquine, Otezla, NSAIDs and leflunomide.
- Has the patient tried another biologic immunomodulator agent that is FDA labeled for this condition?
- If the patient has severe psoriatic arthritis, do they have concomitant severe psoriasis? _____
- If the patient has active ankylosing spondylitis, do they have concomitant severe psoriasis and/or psoriatic arthritis? _____
- If patient is taking another TNF, IL-1 inhibitor, or non-biologic agent like infliximab or etanercept, will it be stopped? _____
- **What is the reason the patient cannot self-administer with a prefilled syringe?** _____

■ **Medication Order**

All Cimzia orders at Agile Infusion are reconstituted lyophilized powder products, not prefilled syringes.

☐ Initial dose of 400mg Cimzia (certolizumab) SubQ injection, given as 2 x 200mg, at start, week 2 and week 4.
☐ Maintenance dose of 200mg Cimzia (certolizumab) SubQ inj every other week after the 1st dose, for 3 months.
☐ Maintenance dose of 400mg Cimzia (certolizumab) SubQ inj, given as 2 x 200mg, every 4 weeks after the 1st dose, for 3 months.

Medication shall be handled and administered according to manufacturer instructions. Check vitals and monitor for signs and symptoms before administration and after completion.

■ **Rescue Management in Case of Reaction**

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.
- Call ordering provider to report reaction.

■ **Ordering Provider Authorization**

Provider Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ Indiv. NPI #: _____ License: _____

Best Contact Person in Office: _____ Direct Phone to Contact Person: _____

Documentation to Include:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.

FAX THIS ORDER AND SUPPORTING DOCUMENTATION TO 201-266-0437 OR UPLOAD USING YOUR SECURE DEDICATED WEBPAGE – TO GET A PERSONAL LINK PLEASE CONTACT THE INTAKE TEAM.