

Certolizumab (Cimzia®) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.
Fax completed form, insurance information and clinical documentation to 414-260-7368.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code(s): _____

Is this the first dose? Yes - Date of first dose: _____ No - Date of next dose: _____

Hepatitis B Status: Titer Date: _____ Positive Negative

TB Status PPD (negative) – date: _____ Active TB Unknown
 Last chest x-ray – date: _____ Other _____
 Past positive TB infection, course taken: _____

Certolizumab (Cimzia®) Prescription

Certolizumab (Cimzia®) 200 mg/mL Kit refill as directed x 1 year

Initial Dose: Inject 400 mg SQ on Weeks 0, 2, and 4.
 Other: _____

Maintenance Dose: Inject 400 mg SQ every 4 weeks (Crohn's disease).
 Inject 200 mg SQ every other week or 400 mg every 4 weeks (ankylosing spondylitis).
 Inject 200 mg SQ every other week – consider 400 mg SQ every 4 weeks (psoriatic or rheumatoid arthritis).
 Other: _____

Ancillary Orders

Medication Orders

Other: _____

Lab Orders

No labs ordered at this time.
 Other: _____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature _____ Date _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____



Original - Medical Records

Froedtert Home and Specialty Infusion
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