Cimzia (certolizumab pegol)

Provider Order Form rev. 5/20/2022

VASCO INFUSION
www.vascoinfusion.com
ph: 602-346-0204 fax: 877-637-6691

PATIENT INFORMATION

Patient Name: DOB:

Patient Phone: Patient Email:

☐ NKDA ☐ Allergies: Weight lbs/kg: Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy ☐ Therapy Change Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

DOCUMENTATION (REQUIRED)

☐ Labs ☐ Insurance Card (front and back) ☐ Current Medications ☐ History/Progress Notes

ICD-10 CODE

☐ K50.90 Crohn's Disease

☐ M06.9 Rheumatoid arthritis

☐ M45.9 Ankylosing Spondylitis

☐ L40.50 Psoriatic Arthritis

☐ L40.0 Plaque Psoriasis

☐ M45.A0 Non-radiographic Axial Spondyloarthritis, unspecified sites

☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg / ☐ PO ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mgIV ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) 100mg IV

☐ Other: _____

Dose: _____ Route: _____ Frequency: _____

MEDICATION ORDER

Cimzia (certolizumab pegol)

Initiation Therapy (also select maintenance therapy order)

☐ 400mg SC (given as 2 SC injections of 200mg each) at week 0, 2 and 4

☐ Other:_____

Maintenance Therapy:

☐ 200mg SC every other week

☐ 400mg SC every 4 weeks

☐ 400mg SC every other week

☐ Other:_____

Order Expiration Date (mm/dd/yy): _____
(If not indicated order will expire one year from date signature)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

☐ **Check here if this is a stat order**