Phone: (305) 306-7147 | Fax: (305) 402-9559 | Email: contact@clearwellinfusion.com

Clearwell
Infusion Centers

CIMZIA (certolizumab pegol)

PATIENT DEMOGRAPHICS

Patient Name: _____

Date of Birth: _____ M: ☐ F: ☐ Address: _____

Phone: _____ City, State, Zip: _____

Email: _____

Allergies:

PRIMARY DIAGNOSIS

ICD-10 Code:

DOCUMENTATION (PLEASE ATTACH)

Clinical / Progress Notes, Labs, Tests supporting primary diagnosis

☐ TB status and date (attach results)

☐ Hepatitis B status and date (attach results)

Clearwell Infusion Centers will draw maintenance labs unless otherwise directed by Referring Provider

PRE-MEDICATION

☐ Acetaminophen 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Ceterizine 10mg PO

☐ Loratadine 10mg PO

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ Other:

PRIMARY MEDICATION ORDER

Dosage & Frequency

☐ 400mg SQ initially and at weeks 2 and 4 (induction)

☐ 200mg SQ every 2 weeks (maintenance)

☐ 400mg SQ every 4 weeks (maintenance)

Patient Weight:

_____ lbs

_____ kg

NOTES

ORDERING PROVIDER

Provider Name: _____ NPI: _____

Practice Name: _____ Phone: _____

Office Contact: _____ Fax: _____

Practice Address: _____

City, State, Zip: _____

Provider Signature: _____ Date: _____