CURBSIDE INFUSION SERVICES

Fax To: 281-406-1047
Email To: referrals@curbsideinfusion.com
Office: 281-406-1046

CIMZIA (certolizumab pegol) infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ◉

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Rheumatoid Arthritis
- ☐ _____ Crohn's Disease
- ☐ _____ Ankylosing Spondylitis
- ☐ Psoriatic Arthritis
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ Quzyttir 10mg IVSP over 1-2 min
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

CIMZIA ORDERS

DOSAGE/FREQUENCY

- ☐ 400mg SQ initially and at weeks 2 and 4 *(induction)*
- ○ 200mg SQ every 2 weeks *(maintenance)*
- ◉ 400mg SQ every 4 weeks

PATIENT WEIGHT

____lbs.

____kg

TB TESTING

- ☐ Perform Quantiferon Gold (QFT Gold)
- ☐ Perform PPD Skin Test

NOTES

ORDERING PROVIDER

Signature **X** _____ Date

Provider _____ Phone _____ Fax _____

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