McLeod Health

Certolizumab Pegol (Cimzia) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Patient Primary Phone Number: _____

Diagnosis (select one):

☐ L40.9 Psoriasis, unspecified

☐ L40.0 Psoriasis vulgaris

☐ M05.___ Rheumatoid Arthritis with rheumatoid factor

☐ M06.___ Rheumatoid Arthritis w/o rheumatoid factor

☐ M45.___ Ankylosing spondylitis

☐ K50.____ Crohn's disease

☐ K50.9 Crohn's disease, unspecified

☐ Other: ICD 10 Code: _____ Diagnosis Description: _____

Drug Orders:

☐ Induction: Certolizumab pegol (Cimzia) (J0717) 400 mg by subcutaneous injection at Week 0, Week 2, and Week 4

☐ Maintenance Dosing: starting 4 weeks after completion of induction therapy

- ☐ Certolizumab pegol (Cimzia) 400 mg by subcutaneous injection every 4 weeks
- ☐ Certolizumab pegol (Cimzia) 200 mg by subcutaneous injection every 2 weeks (rheumatology only)

  administered as 2 divided injections to separate sites in the abdomen or thigh

☐ Other: _____

- Order Duration: One year unless otherwise specified (Other: _____)

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Pre-Screening Requirements:

- Provide TB screening results (PPD or QuantiFERON Gold Test) prior to start of therapy and within last 12 months
- Provide Hepatitis screening (Hepatitis B Surface Antigen) prior to start of therapy and within last 12 months

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received certolizumab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____

and the last date received: _____

Insurance Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

☐ McLeod Regional Medical Center (Florence) ☐ McLeod Health Loris ☐ McLeod Health Cheraw

☐ McLeod Health Seacoast (Little River) ☐ McLeod Health Dillon ☐ McLeod Health Clarendon (Manning)

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.