



INFUSION ORDERS — CIMZIA (certolizumab pegol)

Patient Name: _____ Date of Birth: _____

Patient Weight [kg]: _____

Diagnosis: Rheumatoid Arthritis Crohn's Disease Other _____

Allergies: _____ TB Test Results: _____ Date of TB Test: _____

Hepatitis B Surface Antigen Result: _____

CIMZIA LYOPHILIZED DOSING

Initial Dose

400mg SC at weeks 0, 2, and 4

Maintenance Dose *[Please Select Appropriate Schedule]*

200mg SC every 2 weeks refills 12 _____

OR

400mg SC every 4 weeks refills 12 _____

Prescribing Physician: _____ Date _____

Address: _____

Physician Signature: _____

Physician Phone: _____ Fax: _____

PATIENT DEMOGRAPHICS

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____

Insurance

Carrier: _____ Insured: _____

Group: _____ Policy: _____

Phone: _____

Initial appointment date and time will be verified after insurance approval.