Atrium Health Infusion Center

Referral Status:	☐ New Start ☐ Order Change ☐ Renewal
Preferred Location:	☐ Atrium Health Infusion Center Concord **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Pineville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Southpark **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Huntersville **Fax:** 704-468-3401 ☐ Atrium Health Infusion Center Kenilworth, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Abbey Place, a facility of CMC **Fax:** 704-512-5390 ☐ Atrium Health Infusion Center Cabarrus, a facility of CMC **Fax:** 704-512-5390

Cimzia® (certolizumab pegol) Injection Order (Revised 11/11/2025)

All orders with a √ will be placed.

Patient Demographics		
Patient Name:	Date of Birth:	MRN:
Address:		
City:	State:	Zip Code:
Allergies: (please list all allergies or attach list) ☐ NKDA		

Diagnosis: (Complete the 2nd and/or 3rd Digits of the ICD-10)	
☐ K50.00 Crohn's disease of the small intestine without complications	☐ K50.10 Crohn's disease of the large intestine without complications
☐ K50._____ (complete the 2nd and/or 3rd digit)	☐ K50.80 Crohn's disease of the small and large intesting without complications
☐ M05._____ Rheumatoid Arthritis with rheumatoid factor	☐ M06.___ Rheumatoid Arthritis without rhematoid factor
☐ M45._____ Ankylosing Spondylitis	☐ M46.8____ Other specified inflammatory spondylopathies
☐ M45.A____ Non-radiographic axial spondyloarthritis	☐ L40.5___ Arthropathic Psoriasis
☐ Other:	

Required Documentation: (*required prior to scheduling*)	
Patient Demographic Sheet	If the patient is new to the ordered therapy, indicate washout from previous therapy:
Copy of Insurance Card (front and back)	
Most Recent Labs (*must include labs pertinent to medication ordered*)	☐ No Washout Needed
Consult Note or last 2 Office Visits with referring provider or APP	If the patient is currently on the therapy, indicate date of last infusion: Next infusion due date:
Complete Medication List - Include all tried and failed meds	If this is an order change only, indicate if the current therapy should be administered until insurance approval is received for the new request.
Diagnostic Studies Pertinent to Medication Ordered	☐ Yes ☐ No

Treatment Parameters:
☑ Hold treatment and notify provider IF: - Temperature is GREATER THAN 100oF; - Patient complains of symptoms of acute viral or bacterial infection; - Patient is taking an antibiotic for current infection.
☑ Required lab Results: Hep B Profile and PPD/Quantiferon Gold PRIOR to first treatment (**Fax Labs with Order**)
☑ Notify Provider IF: Hep B Panel: POSITIVE or not on file; PPD/Quantiferon Gold: POSITIVE or not on file

Nursing Communication:
☑ Obtain vital signs pre-treatment. Obtain vital signs post-treatment PRN signs of reaction.
☑ Monitor patient for signs of reaction for 30mins after completion of 1st injection and subsequent injections PRN if previous signs of reaction observed.
☑ Monitor patient fo new onset or worsening congestive heart failure symptoms.

Infusion Therapy:
☑ Certolizumab pegol (Cimzia) 400mg SC at weeks 0, 2 and 4; then: (Please choose one of the following maintenance doses below)
☐ Certolizumab pegol (Cimzia) 200mg SC every 2 weeks
☐ Certolizumab pegol (Cimzia) 400mg SC every 4 weeks

Supportive Care Medications:
☑ Acetaminophen (Tylenol) 500mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give first.
☑ Ibuprofen (Motrin) 800mg PO ONCE PRN mild pain (1-3) or moderate pain (4-6). Give second after acetaminophen.
☑ Ondansetron (Zofran) tablet 4mg PO ONCE PRN nausea/vomiting.

Hypersensitivity Protocol:
☑ Initiate Atrium Health approved hypersensitivity protocol in the event of an acute adverse or anaphylactic infusion/injection reaction. The hypersensitivity protocol can be found on the Atrium Health Infusion Center website at atriumhealth.org/infusion.

Prescriber Information:	
Provider Name:	Phone: Fax:
Practice Name:	NPI:
Address:	Office Contact:
City, State, Zip:	Office Contact Phone Number:

Physician Signature: (*Order expires 12 months from date of signature*) No Stamp Signatures Accepted	
Signature:	Date: