ADVANCED
INFUSION CENTER

Cimzia(certolizumab) Infusion Order

Patient Name: _____ DOB: _____

Allergies: _____ Weight: _____ lb/kg

Diagnosis: please check one of the following

- **Active Ankylosing Spondylitis (M45.9)**
- **Active Axial Spondyloarthritis (M47.9)**
- **Active Psoriatic Arthritis (L40.52)**
- **Moderate to Severe Plaque Psoriasis (L40.0)**
- **Moderate to Severe Crohn's Disease (K50.90)**
- **Moderate to Severe Rheumatoid Arthritis (M06.9)**
- **Other: _____ (ICD 10): _____**

Medication Order: please check one of the following

- **Cimzia 200 mg Sub Q** _____
- **Cimzia 400 mf SubQ** _____
- **Other: Cimzia _____ mg SubQ** _____

For Infusion related reactions refer to AIC Reaction Protocol and notify physician

Physician Signature: _____ Date: _____

Physician Name printed: _____

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