METRO INFUSION CENTER

Phone: 877.448.3627

Fax completed form to:
630-734-7597

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:____________

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.