Beacon Infusion
Healthcare Services

Headquarters Location:
1075 Stephenson Ave, Suite D-2, Oceanport, NJ 07757
Telephone: (833) 223-2266 Fax: (732) 329-2322

CIMZIA MEDICATION ORDER

Patient's Name (Last, First, Middle) _____ **DOB:** _____

■ Diagnosis

Please specify the ICD10 code if using a diagnosis with a ___ noted.

☐ M06.0 Rheumatoid arthritis w/o rheumatoid factor
☐ M06.8 Rheumatoid arthritis, other
☐ M40.0 Psoriasis vulgaris
☐ M45.____ Ankylosing spondylitis (specific ICD10)
☐ M40.52 Psoriatic arthritis mutilans
☐ K50.9____ Crohn's disease (specific ICD10)

■ Details Needed for Authorization

- Proof of patient's negative latent TB test. If test is positive, proof that patient has begun therapy for latent TB.
- Is patient concurrently being treated with any other biologic? _____
- Does the patient have an intolerance, contraindication or hypersensitivity to any of the following agents, or has tried and failed on at least one with at least 3 months of therapy? If yes, circle all that apply. They are: 6-mercaptopurine, aminosalicylates, azathioprine, corticosteroids, mesalamine, methotrexate, sulfasalazine, hydroxychloroquine, Otezla, NSAIDs and leflunomide.
- Has the patient tried another biologic immunomodulator agent that is FDA labeled for this condition?
- If the patient has severe psoriatic arthritis, do they have concomitant severe psoriasis? _____
- If the patient has active ankylosing spondylitis, do they have concomitant severe psoriasis and/or severe psoriatic arthritis? _____
- If patient is taking another TNF, IL-1 inhibitor, or non-biologic agent such as infliximab, etanercept or anakinra, will it be stopped? _____
- If patient is unable to self-administer Cimzia, please provide documentation for the reason why, such as:
  - History of anaphylaxis to related agent despite premedication; or
  - Impairment due to motor/dexterity condition or other physical impairment; or
  - Mental status / cognitive changes; or
  - Past history of compliance issues indicating supervision to ensure adequate drug delivery; or
  - Clinically-diagnosed needle phobia; or
  - Patient's age prohibits successful administration, and care cannot be adequately managed by a caregiver.

Patient's height in ft/in: _____ Patient's weight in lbs: _____

■ Cimzia (certolizumab pegol) Medication Order

☐ Initial dose of 400mg SubQ injection, given as 2 x 200mg, at start, week 2 and week 4.
☐ Maintenance dose of 200mg SubQ injection every other week after the initial dose, for 3 months.
☐ Maintenance dose of 400mg SubQ injection, given as 2 x 200mg, every 4 weeks after the initial dose, for 3 months.

■ Rescue Management in case of Reaction

These include fever, chills, rigors, headache, rash, itching, swelling, edema, nausea, vomiting, abdominal pain, hypotension, and respiratory distress.

- Follow standing reaction orders, including diphenhydramine, methylprednisolone, albuterol and oxygen as needed.
- For severe reactions, administer Epi-pen or equivalent and call 911. Repeat if severe symptoms persist.

■ Ordering Provider Authorization

Provider's Signature: _____ Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____ NPI #: _____ License: _____

STANDARD DOCUMENTATION TO INCLUDE:

- Patient demographics and insurance, including card scans (both medical and pharmacy benefit cards, both sides).
- Most recent chart notes and, if available, last history and physical. All relevant scans, tests and laboratory results.
- If new medication for patient, chart notes which include decision to begin treatment. If not, provide last treatment date.

Fax this order and supporting documentation to (732) 329-2322.