cimplicity®
Confidence in care.

Training Verification Form

The acting home health nurse is required to fax this completed Training Verification via eFax after the home health visit is complete.
All required fields (indicated by *) must be completed in order to receive payment.

VMS Patient ID: Program Type:

Patient Information

By signing this form, I certify that my healthcare provider has provided me with a prescription for CIMZIA® (certolizumab pegol) and that I have received direct medical guidance regarding this treatment from my healthcare provider. I acknowledge that CIMplicity home health is paid for by UCB, Inc. and is facilitated by a licensed home health agency. I understand that by signing the attached HIPAA Patient Authorization Form to Use and Disclose Information, I have consented to the home health agency disclosing the results of today's home health visit to UCB, Inc. I certify that I am at least 18 years of age.

Patient Name_____

Signature*_____Date*_____

Training Information

Training Location:* Street Address_____

City_____State_____Zip_____

Training Date and Time:* Date_____Time_____Total Round Trip Mileage*_____

Visit Results*

☐ Patient received correct formulation as ordered by HCP (If no, do not continue. Stop and notify VMS BioMarketing)
☐ Nurse assessed patient for signs and symptoms of an infection. If patient reports any signs of infection, contact HCP for direction. If unable to reach HCP, do NOT continue until HCP can be notified.
☐ Review storage of CIMZIA in the refrigerator at 36°–46° F, in original package
☐ Review Medication Guide and Product Information
☐ Have patient read and sign HIPAA form (first visit only)
☐ Explain injection procedures to patient/caregiver
☐ Adverse Event/Product Quality Complaint (AE/PQC) was reported during visit
If yes, the approved AE/PQC form was completed and faxed to VMS BioMarketing via eFax within 24 hours? ☐ Yes ☐ No
☐ Nurse reminded patient about CIMplicity telephonic nurse support and provided 1-844-UCBNurse (1-844-822-6877) number to patient
☐ Training was canceled (notify VMS BioMarketing immediately of cancellation)
If yes, reason for cancellation: ☐ Nurse canceled ☐ Patient canceled

Dose	Sites	Exp. Date	Lot Number

Next Visit *(for patients receiving lyophilized powder for reconstitution administration ONLY)*

Location:* Street Address_____

City_____State_____Zip_____

Program Date and Time:* Date_____Time_____

Nurse Information

Agency Name_____

Nurse Name*_____

Nurse Signature*_____

IMPORTANT SAFETY INFORMATION Serious and sometimes fatal side effects have been reported with CIMZIA, including tuberculosis (TB), bacterial sepsis, invasive fungal infections (such as histoplasmosis), and infections due to other opportunistic pathogens (such as Legionella or Listeria). Patients should be closely monitored for the signs and symptoms of infection during and after treatment with CIMZIA. Lymphoma and other malignancies, some fatal, have been reported in children and adolescent patients treated with TNF blockers, of which CIMZIA is a member. CIMZIA is not indicated for use in pediatric patients. Visit www.CIMZIA.com for full Prescribing Information (PI).

cimzia®
(certolizumab pegol)