St. Charles HEALTH SYSTEM	**St. Charles Health System** Adult Ambulatory Infusion Order Certolizumab (CIMZIA)	Patient Name: Date of Birth: *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Treatment Start Date: _____ Allergies: _____
Weight: _____kg Height: _____ cm

REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety
1. FACE SHEET with complete INSURANCE information and patient CONTACT information
2. Recent VISIT NOTE to support treatment (if not available in Epic)
3. LAB RESULTS for any required prescreening (if not available in Epic)
4. DIAGNOSIS CODE _____
5. Patient NAME and DATE OF BIRTH on EVERY page faxed

GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment, and the patient should not be infected. Please send results with order.
3. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

☐ Hepatitis B surface antigen and core antibody total test results scanned with orders.
☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:

Baseline:

☐ Complete Metabolic Panel, Routine, ONCE
☐ CBC with auto differential, Routine, ONCE
☐ C-reactive protein, Routine, ONCE
☐ Sedimentation rate, automated, Routine, ONCE
☐ Labs already drawn. Date: _____

Maintenance:

☐ Complete Metabolic Panel, Routine, ONCE, every visit, every 84 days
☐ CBC with auto differential, Routine, ONCE, every visit, every 84 days
☐ C-reactive protein, Routine, ONCE, every visit, every 84 days
☐ Sedimentation rate, automated, Routine, ONCE, every 84 days

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. VITAL SIGNS: Monitor and record vital signs prior to injection. Monitor and record tolerance, and presence of injection-related reactions after the injection.
3. Administer 400 mg dose as 2 divided doses subcutaneously using provided 23-guage needles to separate sites on the abdomen or thigh. Rotate injection sites. Do not administer to areas where skin is tender, bruised, red, or hard.

MEDICATIONS:

Initial Dose:

☐ certolizumab (CIMZIA) 400 mg, subcutaneous for 3 doses on weeks 0, 2, and 4 (administered as 2 injections of 200 mg each)

Maintenance Dose:

☐ certolizumab (CIMZIA) 400 mg, subcutaneous, every 4 weeks beginning week 8 (administered as 2 injections of 200 mg each)

☐ certolizumab (CIMZIA) 200 mg, subcutaneous, every 2 weeks beginning week 6

INFUSION MONITORING/REACTION:

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

☐ Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

_____

Patient will be treated at the following infusion location:

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☑ St. Charles Outpatient Infusion Center
2500 NE Neff Road, Bend, OR 97701
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION

Signature: _____ License #: _____ Date: _____

Print Name: _____ Phone: _____ Fax: _____

Plan will expire 1 year after signature date at which time a new order will need to be placed