(certolizumab pegol)

CIMZIA Infusion Orders

Patient Name _____ DOB _____ Gender: ⬭ M ⬭ F

Phone_____

DIAGNOSIS: *Please provide IDC-10 Code*

☐ _____Rheumatoid Arthritis (RA)
☐ _____Crohn's Disease
☐ _____Ankylosing Spondylitis
☐ _____ Psoriatic Arthritis
☐ _____(Other)

PRE-MEDICATION:

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ _____Other
☐Solu-Medrol 125mg IVP
☐Solu-Cortef 100mg IVP
☐Diphenhydramine 25mg IVP
☐_____Other

CIMZIA ORDERS:

DOSAGE/FREQUENCY:

⬭ **400 mg SQ initially and at weeks 2 and 4 (induction)**
⬭ **200mg/kg every 2 weeks (maintenance)**
⬭ **400 mg/kg every 4 weeks (maintenance)**
● ***Emergency Orders and Treatment per Specialty Infusion Center Anaphylaxis Policy***

PATIENT WEIGHT

_____**LBS**
_____**KG**

TB TESTING

⬭ **Perform Quantiferon Gold (QFT Gold)**
⬭ **Perform PPD Skin Test**

NOTES:

Nursing Orders

- Assess patient prior to each infusion
- Provide patient/caregiver education related to disease process, therapy, infection control, drug use, side effects and precautions, emergency plan
- Weigh patient every visit and record
- Monitor vital signs initially and throughout infusion per manufacturer recommendations
- Administer injection as ordered

ORDERING PROVIDER:

Signature _____ **Printed Name:** _____**Date**_____

Practice _____**Phone**_____ **Fax** _____

PLEASE FAX COMPLETED ORDER TO SPECIALTY INFUSION CENTER 231-600-7058

REV: 3/2023