Oregon Medical Group Infusion Center

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Phone: 541-741-0387 Fax: 541-242-4634

Certolizumab (Cimzia) Orders

Name: ______________________________________ DOB: _____________________________

Diagnosis/Indication: ___________________________ ICD-10 Code: ________________________

Weight: ___________________

1. Administer Certolizumab SQ into the abdomen or thigh:
   ☐ **Initial** 400 mg SQ, repeat dose 2 and 4 weeks after followed by **maintenance** regimen of 200 mg every 2 weeks
   ☐ **Initial** 400 mg SQ, repeat dose 2 and 4 weeks after followed by **maintenance** regimen of 400 mg every 4 weeks

   Note: each 400 mg dose should be administered as 2 injections of 200 mg each.
2. Pre-medications to be given 30 minutes prior to injection (optional)

   ☐ OMG Infusion Center Pre-Medication Protocol
   OR
   ☐ Administer the following routine pre-medications prior to each infusion
   - ☐ Acetaminophen (Tylenol) 650 mg PO
   - ☐ Antihistamine (Select one)
     - ☐ Diphenhydramine (Benadryl) 25 mg PO
     - ☐ Diphenhydramine (Benadryl) 25 mg IV infusion over < 10 mins
     - ☐ Loratadine (Claritin) 10 mg PO
   - ☐ Methylprednisolone (Solu-Medrol) 40 mg IV infusion over < 10 min, not to exceed 50 mg/min
   - ☐ Methylprednisolone (Solu-Medrol) 100mg IV infusion over < 10 min, not to exceed 50mg/min
   - ☐ Ondansetron 4 mg IV **OR** ☐ Ondansetron 8 mg IV

   ☐ Other: ____
3. For infusion reaction (**Must select one to be considered a complete order**)

   ☐ Acute Infusion Reaction Protocol

   ☐ Other ____

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 (non-OMG providers). 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 (non-OMG providers).

Provider Signature: ______________________________________ Date: ____________
(NO PROVIDER STAMPS) (Orders expire after 365 days)

Provider's Printed Name: ___________________________________Time: ___________