LEGACY HEALTH	**Legacy Day Treatment Unit Provider's Orders** Adult Ambulatory Infusion Order CERTOLIZUMAB (CIMZIA)	**Patient Name:** **Date of Birth:** **Med. Rec. No** (TVC MRN Only):
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		

Anticipated Start Date: _____ **Patient to follow up with provider on date:** _____
*****This plan will expire after 365 days, unless otherwise specified below*****

Orders expire: _____

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis: _____ **Diagnosis Code:** _____

GUIDELINES FOR PRESCRIBING:

1. Send **FACE SHEET, INSURANCE CARD and most recent provider chart or progress note**.
2. A tuberculosis screening (Tuberculin skin test or QuantiFERON Gold blood test) must result negative within a year prior to initiation of treatment
3. Hepatitis B (Hep B surface antigen AND core antibody) screening must be completed prior to initiation of therapy and the patient should not be infected

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

- Hepatitis B Surface AG Result Date: _____ ☐ Positive / ☐ Negative
- Hepatitis B Core AB Qual, Result Date: _____ ☐ Positive / ☐ Negative
- Tuberculin Test Result Date: _____ ☐ Positive / ☐ Negative
- QuantiFERON Gold Test Result Date: _____ ☐ Positive / ☐ Negative

LABS TO BE DRAWN (orders must be placed in TVC EPIC by ordering provider if TVC provider):

☐ Basic Metabolic Set, Routine, every _____(visit)(days)(weeks)(months)- **Circle one**
☐ CBC with differential, Routine, every _____(visit)(days)(weeks)(months)- **Circle one**
☐ Other: _____

PRE-MEDICATIONS: (Note: pre-medications are not routinely recommended)

☐ acetaminophen (TYLENOL) tablet: 650 mg by mouth once 30 minutes prior to infusion
☐ diphenhydramine (BENADRYL) tablet: 25 mg by mouth once 30 minutes prior to infusion
☐ cetirizine (ZYTREC) tablet: 10 mg by mouth once 30 minutes prior to infusion **(Choose as alternative to diphenhydramine if needed)**
☐ Other: _____ by mouth once 30 minutes prior to infusion
☐ No routine pre-medications necessary

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MEDICATIONS: (must check at least one):

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

AS NEEDED MEDICATIONS:

- acetaminophen 650 mg oral, EVERY 4 HOURS AS NEEDED for headache, fever, chills or malaise
- diphenhydramine 25 mg oral, EVERY 4 HOURS AS NEEDED for itching

NURSING ORDERS (TREATMENT PARAMETERS):

1. Vital signs, every visit: Monitor and record vital signs prior to injection. Monitor and record tolerance, and presence of injection-related reactions after the injection
2. Nursing communication orders, every visit: Manage hypersensitivity reactions per LH 906.6606
3. Administer 400 mg dose as two 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

HYPERSENSITIVITY MEDICATIONS: Refer to LH policy 906.6606 Initiation of Emergency Measures for Adult Oncology, Radiation Oncology and Infusion Clinic Patients

1. diphenhydramine 25-50 mg IV, AS NEEDED x1 for hypersensitivity reaction (Max dose: 50 mg)
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. hydrocortisone 100 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. naloxone (Narcan) 0.4 mg IV, AS NEEDED x1 dose for diminished respiratory rate
6. sodium chloride 0.9% 1000 mL IV, AS NEEDED x 1 dose for alteration in hemodynamic status
7. Nursing communication order, every visit: Please follow treatment algorithm for acute infusion reaction

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Please check the appropriate box for the patient's preferred clinic location:

☐ **Legacy Day Treatment Unit**
700 NE 87th Avenue, Suite 360
Vancouver, WA 98664
Phone number: 360-896-7070
Fax number: 360-487-5773

☐ **Legacy Salmon Creek Day Treatment Unit**
2121 NE 139th Street, Suite 110
Vancouver, WA 98686
Phone number: 360-487-1750
Fax number: 360-487-5773

☐ **Legacy Silverton STEPS Clinic**
Legacy Silverton Medical Center
342 Fairview Street
Silverton, OR 97381
Phone number: 503-873-1670
Fax number: 503-874-2483

☐ **Legacy Emanuel Day Treatment Unit**
501 N Graham Street, Suite 540
Portland, OR 97227
Phone number: 503-413-4608
Fax number: 503-413-4887

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ Fax: _____

Organization/Department: _____