



Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071



ADULT AMBULATORY INFUSION ORDER
Certolizumab (CIMZIA)

Page 1 of 2

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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

Weight: _____ kg Height: _____ cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ Patient to follow up with provider on date: _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note.**
2. Hepatitis B screening (surface antigen and core antibody) must be completed prior to initiation of therapy
3. Tuberculosis screening (Tuberculin skin test or QuantiFERON Gold blood test) must result negative within the past year. Patients with active disease should not receive treatment.
4. Patients should have regular monitoring for hepatitis B reactivation, tuberculosis, infection, new or worsening heart failure, lupus-like syndrome, and malignancy.

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

- Hepatitis B Surface AG, serum, Routine, ONCE
- Hepatitis B Core AB Qual, serum, Routine, ONCE
- QuantiFERON Gold, serum, Routine, ONCE

OR

- Hepatitis B **surface antigen** and **core antibody** test results included with orders
- QuantiFERON Gold test results included with orders
- Tuberculin skin test results included with orders

LABS:

- CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*

MEDICATIONS:

- **certolizumab (CIMZIA), subcutaneous, ONCE**

Initial Dose:

- 400 mg for 3 doses on week 0: _____, week 2: _____, week 4: _____

Maintenance Doses:

- 400 mg every 4 weeks beginning week 8: _____
- 200 mg every 2 weeks beginning week 6: _____



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NURSING ORDERS:

- Administer 400 mg dose as 2 divided doses subcutaneously using provided 23-gauge 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
- Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

By signing below, I represent the following:

I am responsible for the care of the patient (*who is identified at the top of this form*);

I hold an active, unrestricted license to practice medicine in: Oregon _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ Date/Time: _____
 Printed Name: _____ Phone: _____ Fax: _____

OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

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

- | | |
|--|--|
| <input type="checkbox"/> Beaverton
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058 | <input type="checkbox"/> NW Portland
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058 |
| <input type="checkbox"/> Gresham
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058 | <input type="checkbox"/> Tualatin
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058 |

Infusion orders located at: www.ohsuknight.com/infusionorders