Lake Charles Memorial Health System

1PO

PO_ CIMZIA ORDER SET

Last Revised: 07/08/2022

Certolizumab (Cimzia) Order Set:

Patient Name: _____ DOB: _____

Height: _____ Weight: _____ (kg) Allergies: _____

Assign as Outpatient

Criteria for Administration:

A negative TB skin test or other appropriate documentation of TB status must be faxed to 430-6976 prior to scheduling of appointment for patient.

Diagnosis:

____M05._____Rheumatoid Arthritis

____L40. _____Psoriasis

____Other (ICD-10 Code): _____

____M06. _____Rheumatoid Arthritis

____L40. _____Psoriatic Arthritis

Labs: To be done per MD office as Outpatient prior to admittance to Infusion Center.

Nursing: Confirm TB and hepatitis B status (or has received hepatitis B vaccination). Assess patient for active infection prior to initiation of therapy: notify MD if present.

____**Certolizumab–Initial Dosing:**

- Certolizumab 400 mg SQ every 2 weeks x 3 doses (Days 1, 14 and 28), then certolizumab 400 mg SQ every 4 weeks.

____**Certolizumab–Maintenance Dosing:**

- Certolizumab 400 mg SQ every 4 weeks

Severe Reactions: **I**nitiate anaphylaxis protocol and notify MD.

Discharge when complete

New MD order required every 6 months unless defined in original order

Physician Signature: _____ Date/Time:_____