Columbus Community Hospital
Columbus, Nebraska
DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here ☐

PHYSICIANS ORDERS
(including Medications)

Certolizumab (CIMZIA) Injection (8/2024) Page 1 of 2

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 (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.
3. 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. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.

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

- ☐ Hepatitis B surface antigen and core antibody test results included with orders
- ☐ Tuberculin skin test or QuantiFERON Gold test results included with orders
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:

- ☐ CBC with differential, Routine, ONCE, every_____ (visit)(days)(weeks)(months) – Circle One
- ☐ Other: _____

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. Administer 400 mg dose as 2 divided doses subcutaneously to separate sites on the abdomen or thigh. Rotate injection sites. Do not administer to areas where skin is tender, bruised, red, or hard.
3. If vascular access is needed, follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.

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: _____

(cont.)

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PHYSICIANS ORDERS
(including Medications)

Certolizumab (CIMZIA) Injection

HYPERSENSITIVITY:

1. NURSING COMMUNICATION – If hypersensitivity reactions develop, refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Continue to assess as grade of severity may progress.
5. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:

- **Acetaminophen**, **975 mg**, PO, x 1 dose, AS NEEDED for hypersensitivity or infusion reaction.
- **DiphenhydrAMINE inj, 50 mg**, IV, AS NEEDED for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
- **Hydrocortisone Sodium Succinate, 100 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Famotidine, 20 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
- **0.9% Normal Saline, 1000 mL**, IV, 150mL/hr, AS NEEDED for hypersensitivity or infusion reaction.
- **EPINEPHrine HCl (1mg/1mL), 0.3 mg**, IM injection, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.

My NPI 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:** _____