Ascension Rx

Certolizumab (Cimzia) Injection Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☑ Baseline
    - ☑ CMP
    - ☑ CBC with Differential
    - ☑ CRP
    - ☑ TB screening (QuantiFERON or alternative)
    - ☑ Hepatitis Screening prior to therapy (HBsAg, HepB core Ab total, HCV)
    - ☑ Hepatitis C Antibody
    - ☑ HIV
  - ☑ Maintenance (every _____)
    - ☑ Hepatic Function Panel
    - ☑ CBC with Differential
- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____

Nursing Order

- ☑ Do not administer Certolizumab with an active infection, including clinically important localized infection, or if patient is taking antibiotics for current infection.
- ☑ Verify patient has a negative hepatitis B immune
- ☑ Verify patient has negative TB status or adequate TB treatment
- ☑ Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

Pre-Medications (Not routinely recommended, use only if clinically indicated)

- ☐ Acetaminophen 650 mg PO once
- ☐ Dexamethasone 20 mg IV once

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- ☐ Diphenhydramine 25 mg PO once
- ☐ Diphenhydramine 25 mg IV once
- ☐ Diphenhydramine 50 mg PO once
- ☐ Diphenhydramine 50 mg IV once
- ☐ Famotidine 20 mg IV once
- ☐ Famotidine 20 mg PO once
- ☐ Dexamethasone 20 mg PO once
- ☐ Methylprednisolone 125 mg IV once
- ☐ Methylprednisolone 40 mg IV once
- ☐ Other: _____

Medication Orders (select loading & maintenance dose)

Loading Dose

- ☐ Certolizumab 400 mg SQ once initially and at weeks 2 and 4

Maintenance Dose

- ☐ Certolizumab 200 mg SQ once every other week
- ☐ Certolizumab 400 mg SQ once every 4 weeks
- ☐ Certolizumab _____ mg SQ once every _____ weeks

Refills:
(Refills for one year from date of signature unless indicated)

☐ Zero ☐ For 12 months ☐ _____

Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Administration Instructions

Administer into the abdomen, thigh, or outer area of upper arm. Rotate injection sites; if the same injection site is chosen, do not inject into the same spot used for the first injection. Administer two separate 200mg injections immediately one after the other.

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated

3/20/2026