GOLIMUMAB (SIMPONI ARIA®) PRESCRIBER ORDER FORM

Patient Name:		**Date of Birth:**		**Gender:**
Address:				
Patient Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs. ☐ kg

Clinical Information

Primary Diagnosis Description:		**ICD-10 Code:**	
Is this the first dose?	☐ Yes – date of first dose: ☐ No – date of last dose:	**Hepatitis B Status:**	Titer Date: ☐ Positive ☐ Negative
TB Status:	☐ PPD (negative) – date: _____ ☐ Active TB ☐ Last chest x-ray – date: _____ ☐ Unknown ☐ QuantiFERON or T Spot Assay result and date: _____ ☐ Past positive TB infection, course taken:_____		

Golimumab (Simponi Aria®) Prescription

Golimumab (Simponi Aria®) refill as directed x 1 year

Initial Dose: ☐ Infuse 2 mg/kg IV over 30 minutes on Weeks 0 and 4.

☐ Other: _____

Maintenance Dose: ☐ Infuse 2 mg/kg IV over 30 minutes every 8 weeks.

☐ Other: _____

Ancillary Orders

Anaphylaxis Kit

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders

☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may use own supply or patient may decline.

☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may use own supply or patient may decline.

☐ Methylprednisolone sodium succinate 40 mg IV push 20 minutes prior to infusion.

☐ Other: _____

IV Flush Orders

☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.

☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use.
For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

☐ No labs ordered at this time.

☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.
If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: _____ **Date:** _____

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State:	**Zip:**	**Office Contact:**

Fax completed form, insurance information, and clinical documentation to:

