

**ORDERING OFFICE, ALSO FAX:**

- Most recent labs
- Supporting clinicals / Recent H&P
- Insurance card, front and back

# Golimumab (Simponi Aria)

Provider Order Form



Date:	Patient Name:	DOB:
ICD-10 code (required):		
ICD-10 description:		
<input type="checkbox"/> NKDA Allergies:		Weight lbs/kg:
Ordering Provider:		Provider NPI:
Referring Practice Name:		Phone: Fax:
Practice Address:		City: State: Zip Code:
<b>LABORATORY ORDERS</b>		
<input type="checkbox"/> CBC <input type="checkbox"/> at each dose <input type="checkbox"/> every _____ <input type="checkbox"/> CMP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____ <input type="checkbox"/> CRP <input type="checkbox"/> at each dose <input type="checkbox"/> every _____ <input type="checkbox"/> Other:		
<b>PRE-MEDICATION ORDERS (ADMINISTER 30 MINUTES PRIOR TO PROCEDURE)</b>		
<input type="checkbox"/> acetaminophen (Tylenol) <input type="checkbox"/> 500mg / <input type="checkbox"/> 650mg / <input type="checkbox"/> 1000mg PO <input type="checkbox"/> cetirizine (Zyrtec) 10mg PO <input type="checkbox"/> loratadine (Claritin) 10mg PO <input type="checkbox"/> diphenhydramine (Benadryl) <input type="checkbox"/> 25mg / <input type="checkbox"/> 50mg <input type="checkbox"/> PO / <input type="checkbox"/> IV <input type="checkbox"/> methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg / <input type="checkbox"/> 125mg IV <input type="checkbox"/> Other: Dose:                      Route:                      Frequency:		
<b>INFUSION THERAPY</b>		
<input checked="" type="checkbox"/> Golimumab (Simponi Aria) in 100ml 0.9% sodium chloride, intravenous infusion over 30 minutes (use in line filter 0.22 micron or less) <ul style="list-style-type: none"> <li>▪ Dose: <input type="checkbox"/> 2mg/kg = _____mg / <input type="checkbox"/> other _____mg/kg</li> <li>▪ Frequency: <input type="checkbox"/> induction: week 0, and 4, and then every 8 weeks / <input type="checkbox"/> maintenance: every 8 weeks / <input type="checkbox"/> other: _____</li> <li>▪ Duration: Infuse over 30 minutes</li> </ul> <input checked="" type="checkbox"/> Flush with 0.9% sodium chloride at the completion of infusion  <input type="checkbox"/> Patient is required to stay for 30-minute observation post infusion <input type="checkbox"/> Patient is NOT required to stay for observation time <input type="checkbox"/> Refills: <input type="checkbox"/> Zero / <input type="checkbox"/> for 12 months / <input type="checkbox"/> _____ (if not indicated order will expire one year from date signed)		
<b>GENERAL PLAN COMMUNICATION</b>		
Special instructions/notes:		

Ordering Provider: Initial here \_\_\_\_\_ and proceed to the next page.

## ADULT REACTION MANAGEMENT

- ☐ Observe for **hypersensitivity reaction**: Fever, chills, rigors, pruritus, rash, cough, sneezing, throat irritation
- ☐ If reaction occurs:
  - Stop infusion
  - Maintain/establish vascular access
  - Notify referring provider
  - Consider giving the following PRN
    1. Acetaminophen (Tylenol) 650mg PO **OR** \_\_\_\_\_mg for pain or fever > 38 C/100.4 F
    2. Diphenhydramine (Benadryl) 25-50mg in 10ml NS slow IV push for rash, itching, pruritis
    3. Ranitidine 25mg in 10ml NS slow IV push over 5 minutes (Consider if patient already given IV Benadryl)
    4. Ondansetron (Zofran) 4mg Slow IV push over 5 minutes for nausea or vomiting.
    5. Methylprednisolone (Solumedrol) 125mg **OR** \_\_\_\_\_mg slow IV push.
    6. Other \_\_\_\_\_
  - When symptoms resolve resume infusion at 50% previous rate and increase per manufacturer's guidelines
- ☐ **Severe allergic/anaphylactic reaction:**
  - If symptoms are rapidly progressing or continuing after administration of prn medications above and signs symptoms of severe allergic/anaphylactic reaction (angioedema, swelling of the mouth, tongue, lips, or airway, dyspnea, bronchospasm with or without hypotension or hypertension.)
    1. Call 911
    2. Consider giving epinephrine (1:1000 strength) 0.3ml IM. May repeat every 5-15 minutes to a maximum of 3 doses.
    3. Treat hypotension with 500ml 0.9% sodium chloride bolus. Repeat as needed to maintain systolic BP >90.
    4. Have oxygen by nasal canula available and administer 2-15 liters, titrate to keep Spo2 >92%
    5. Have Automated External Defibrillator available
    6. Notify referring provider. If unable to reach referring provider, notify Local Medical Director.
    7. Discontinue treatment

Perform test for latent TB; if positive, start treatment for TB prior to starting SIMPONI ARIA. Monitor all patients for active TB during treatment, even if initial latent TB test is negative.

Prior to initiating SIMPONI ARIA, test patients for hepatitis B viral infection. All patients should be tested for HBV infection before initiating TNF-blocker therapy.

\_\_\_\_\_  
Patient Name

\_\_\_\_\_  
Patient Date of Birth

\_\_\_\_\_  
Provider Name (Print)

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date

Please fax the order form to (440) 443-0700

