

# Simponi Aria (Golimumab)

## PATIENT INFORMATION

Referral Status (check one):  New Referral  Updated Order  Order Renewal

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

NKDA  Allergies: \_\_\_\_\_ Weight \_\_\_\_\_ Please specify:  lbs  kg Height: \_\_\_\_\_

Patient Status (check one):  New to Therapy  Continuing Therapy | Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

**REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**

## PRESCRIPTION

### NURSING

- TB status and date (Please provide results)  
\_\_\_\_\_
- Hepatitis B status and date (Please provide results)  
\_\_\_\_\_

### PRE-MEDICATION ORDERS

- acetaminophen (Tylenol)  500mg |  650mg |  1000mg PO
  - cetirizine (Zyrtec) 10mg PO
  - loratadine (Claritin) 10mg PO
  - diphenhydramine (Benadryl)  25mg |  50mg |  PO |  IV
  - methylprednisolone (Solu-Medrol)  40mg |  125mg IV
  - hydrocortisone (Solu-Cortef)  100mg IV
  - Other: \_\_\_\_\_
- Dose: \_\_\_\_\_ Route: \_\_\_\_\_  
 Frequency: \_\_\_\_\_

### THERAPY ADMINISTRATION

- Golimumab** (Simponi Aria) in 100ml 0.9% sodium chloride, intravenous infusion over 30 minutes (use in line filter 0.22 micron or less)
  - Dose:  2mg/kg /  other \_\_\_\_\_ mg/kg
  - Frequency:  induction: week 0, and 4, and then every 8 weeks /  maintenance: every 8 weeks /  other: \_\_\_\_\_
- Duration: Infuse over 30 minutes
- Flush with 0.9% sodium chloride at infusion completion
- Patient required to stay for 30-min observation
- Refills:  Zero /  for 12 months /  \_\_\_\_\_  
 (if not indicated order will expire one year from date signed)

## SPECIAL INSTRUCTIONS

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_  
 Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_  
 Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\_\_\_\_\_  
 Provider Name (Print) Provider Signature Date