

Simponi Aria (Golimumab)

Infusion Order Form – Page 1 of 1



Preferred Clinic Location

- ☐ **Harbor Health Park Bend Clinic**
2200 Park Bend Drive, Bldg 2, Suite 300, Austin, TX 78758
P: (855) 481-8375
F: (512) 233-2288

Patient Information

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: _____ Patient Name: _____ DOB: _____
ICD-10 code (required): _____ ICD-10 description: _____
☐ NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____
Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Provider Information

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

Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list
- Clinicals to support one or more of the following:
 - Patient has moderately to severely active rheumatoid arthritis and is taking methotrexate
 - Patient has active psoriatic arthritis
 - Patient has active ankylosing spondylitis

Orders

NURSING

- ☒ Nursing care per [Harbor Health Nursing Procedures](#) and [Harbor Health Adverse Reaction Management Protocol](#).
☒ Verify TB status and date (Please provide results) _____
☒ Verify Hepatitis B status and date (Please provide results) _____

LABORATORY

- ☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION

- ☐ 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

- ☒ **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
• Route: Intravenous
• 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 is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

Perform test for latent TB; if positive, start TB treatment 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.

Provider Name (Print): _____

Provider Signature: _____

Date: _____