ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

Fax all infusions to: 833-380-8800

Please mark the appropriate infusion center:

- ❑ Allenmore Infusion Center
- ❑ Auburn Infusion Center
- ❑ Gig Harbor Infusion Services
- ❑ Puyallup Infusion Center
- ❑ DHEC Infusion Center
- ❑ North Spokane Infusion Center
- ❑ North Star Lodge Infusion Center

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Golimumab (Simponi Aria)

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

Diagnosis:
❑ Rheumatoid Arthritis
❑ Other_____

ICD -10 Code:
❑ _____
❑ _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

☑ **Reason patient not able to self-administer medication:** _____

Baseline labs required:

- CBC Date: _____/_____/_____ Results: _____
- Latent TB testing Date: _____/_____/_____ Results: _____
- HBV screening Date: _____/_____/_____ Results: _____
- HCV screening Date: _____/_____/_____ Results: _____

Maintenance labs required:

- CBC
- Annual Latent TB testing

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Patient weight _____ lb/kg (required)

Treatment Regimen:
Golimumab (Simponi Aria) Dose: Administered in 50 ml NS with 0.22 micron filter infused over 30 minutes
Initiation dose: ❑ 2 mg/kg = _____ mg IV every 4 weeks for 2 doses then every 8 weeks
Maintenance dose: ❑ 2 mg/kg = _____ mg IV every 8 weeks

☑ **Vital Signs:** Check vital signs prior to and at completion of infusion.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):

- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for futher orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expire in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
GOLIMUMAB (Simponi Aria)

MultiCare

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