

MHS Home/Alternate Site Infusion Services Golimumab (Simponi Aria) Infusion Order Set

ALL ORDERS MUST BE SIGNED AND DATED BY PRESCRIBING PROVIDER

Patient Name: _____	DOB: ____/____/____	Weight: _____ lb/kg
----------------------------	----------------------------	----------------------------

Patient Phone Number: (____) _____-_____	Requested Date of Service: ____/____/____
---	--

Patient Allergies: _____

Diagnosis: _____ **ICD – 10 Code:** _____

- Z45.2: Encounter for adjustment and management of vascular access device
- Z95.828: Presence of other vascular implants and grafts

Baseline Labs Required:

- | | | |
|----------------------------------|----------------------|---------------|
| • Latent TB testing/Quantiferon: | Date: ____/____/____ | Result: _____ |
| • CBC | Date: ____/____/____ | Result: _____ |
| • HBV screening | Date: ____/____/____ | Result: _____ |
| • HCV screening | Date: ____/____/____ | Result: _____ |

Maintenance Labs Required:

- Latent TB testing every 12 months
- CBC every 12 months

Lab Orders: _____

Additional Requirements: In addition to order, please include H&P with documentation to support diagnosis. Must include ICD-10 Code(s) and supporting labs. **** Emergency phone number for provider _____ (required) ****

Provider Order for Golimumab (Simponi Aria) Infusion

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

Biologic Infusion:

Golimumab (Simponi Aria) administered in 100 mL NS infused over 30 minutes using 0.22 micron filter.

Patient Weight: _____ kg

- Initiation: 2 mg/kg = _____ mg IV every 4 weeks for 2 doses, then every 8 weeks
- Maintenance: 2 mg/kg = _____ mg IV every 8 weeks

Additional Medications:

- 0.9% NaCl (NS) PF flush in 10 mL syringe: Administer 5 – 30 mL IV as needed for establishing and maintaining IV access and for flushing IV line post infusion.
- Heparin: 100 units/mL for port OR 10 units/mL for other central line/midline, 3-5 mL PRN for de-accessing line.
- Cathflo (alteplase) 2 mg: Instill 2 mg (2 mL) into occluded catheter as needed for CVC/CVAD occlusion.
- Diphenhydramine 25 mg IV once, as needed for itching.
- Acetaminophen 325-650 mg tab/cap by mouth once, as needed for pain.

CONTINUED ON NEXT PAGE

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:

Name:
MRN:
DOB:

Pre-printed order – Page 1 of 2
Golimumab (Simponi Aria) Order Set
MultiCare

Skilled Nurse Interventions:

- Admit (first visit) patient to services for home infusion therapy of Golimumab (Simponi Aria).
- Complete Skilled Nurse visit with each infusion for ongoing home infusion therapy of Golimumab (Simponi Aria).
- Obtain vital signs (TPR & B/P) at baseline and at completion of infusion.
- Obtain patient weight at each visit.
- Establish IV access and flush per policy to maintain patency.
- Draw labs as ordered.
- Withdraw ordered dose of Golimumab (Simponi Aria) (concentration prior to dilution is 12.5 mg/mL).
- Add reconstituted medication to prepared bag of Normal Saline 0.9% for a final volume of 100 mL (remove same volume of NS prior to adding medication).
- Infuse Golimumab (Simponi Aria) as prescribed.
- Once infusion is complete, flush IV line with Normal Saline 0.9% as prescribed.
- If vital signs are stable after infusion, Skilled Nurse will discontinue IV access and complete visit.

If Hypersensitivity Reaction Develops (fever, chills, hypotension, rigors, itching, rash, etc.):

The Skilled Nurse will:

- STOP THE INFUSION.
- Administer emergency medications as prescribed (below).
- For mild infusion reaction, may restart the infusion at a slower rate (verified with pharmacist) if symptoms resolve with medication.
- Contact Emergency Medical Services (EMS/911) if indicated.
- Increase vital sign monitoring to every 5 minutes.
- Contact provider via emergency phone number for additional instructions.
- Notify MHS Home/Alternate Site Infusion Pharmacist AND Nurse Supervisor.

Emergency Medications: To be administered by skilled nurse as needed for hypersensitivity reactions.

- **Diphenhydramine 50 mg/mL solution:** Inject **0.5 mL** (25 mg) into the vein via slow IV push over at least 2 minutes as needed for rash, itching, hives, flushing of skin, and/or mild-to-moderate hypersensitivity reaction. May give IM if no IV access available. Max dose = 50 mg.
- **Methylprednisolone sodium succinate (SOLU-MEDROL) 125 mg/2 mL solution:** Inject **2 mL** (125 mg) into the vein as a slow IV push over at least 3 minutes once, as needed for hives, flushing of the skin, shortness of breath, chest tightness, tachycardia (HR>140 bpm), and/or moderate-to-severe hypersensitivity reaction. May give IM if no IV access available.
- **EPINEPHrine (Adrenalin) 1 mg/mL solution:** Inject **0.3 mL** (0.3 mg) intramuscular every 5-15 minutes as needed (maximum 3 doses) for severe allergic reaction or anaphylaxis AND call 911 and provider.
- **Acetaminophen (Tylenol) 325 mg tab:** Take **2 tablets** (650 mg) by mouth as needed for fever (PRN for temperature > 101F/38.3C) and/or mild-to-moderate hypersensitivity reaction.
- **0.9% NaCl (NS) solution:** Infuse **500 mL** into the vein via gravity as needed at a rate needed to maintain IV access.
- **Oxygen:** Initiate oxygen by RN PRN chest pain or dyspnea to keep SpO2>90%. For 1-6 LPM, use NC. For 6-10 LPM, use simple mask.

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)

I certify that this patient is safe and appropriate to receive therapy from Home Infusion Services.

Provider Signature: _____ **Printed Name:** _____ **Date:** _____

NPI: _____ Orders expire in 12 months unless otherwise specified: _____

Provider/Clinic Information:

Address: _____

Phone #: _____ Fax#: _____

Return completed orders to:

MultiCare Home/Alternate Site Infusion Services
253-459-6650 (phone) / 253-864-2785 (fax)

FOR MHS HOME/ALTERNATE SITE INFUSION SERVICES USE ONLY

Patient Identification:

Name:
MRN:
DOB:

Pre-printed order – Page 2 of 2
Golimumab (Simponi Aria) Order Set
MultiCare

Revised 10/24