# Golimumab (Simponi Aria)

***Provider Order Form*** *rev. 10/12/2022*

## 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:

## NURSING

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
**NOTE:** IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

☑ TB status and date (Please provide results)

_______________________________________________

☑ Hepatitis B status and date (Please provide results)

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## 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: ____________________________________

## SPECIAL INSTRUCTIONS

## LABORATORY ORDERS

- ☐ CBC ☐ at each dose ☐ every ____________________
- ☐ CMP ☐ at each dose ☐ every ____________________
- ☐ CRP ☐ at each dose ☐ every ____________________
- ☐ Other: ________________________________________

## 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 = _______mg / ☐ 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 is required to stay for 30-minute observation period

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ ______________________
(if not indicated order will expire one year from date signed)

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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** |
|---|---|---|

## FAX NUMBERS

| | | | | |
|---|---|---|---|---|
| | ☐ CONNECTICUT: 860-955-1532 | ☐ HARRISBURG: 844-859-4235 | ☐ PALM BEACH: 561-768-9044 | ☐ TAMPA: 844-946-0849 |
| | ☐ CHICAGO: 312-253-7244 | ☐ INDIANAPOLIS: 844-983-2028 | ☐ PHILADELPHIA: 844-820-9641 | ☐ WEST TN/AR: 888-615-1445 |
| ☐ BAY AREA: 844-889-0275 | ☐ COLUMBUS: 844-627-2675 | ☐ JACKSONVILLE: 904-212-2338 | ☐ RALEIGH: 919-287-2551 | ☐ MIDDLE TN: 888-615-1445 |
| ☐ CHARLOTTE: 336-663-0143 | ☐ DAYTONA: 386-259-6096 | ☐ KANSAS CITY: 844-900-1292 | ☐ SARASOTA: 941-870-6550 | ☐ EAST TN: 615-425-7427 |
| ☐ CINCINNATI: 844-946-0868 | ☐ FT. LAUDERDALE: 754-946-2052 | ☐ ORLANDO: 844-946-0867 | ☐ SOUTHWEST FL: 813-283-9144 | |