



**St. Charles Health System**

Adult Ambulatory Infusion Order  
Golimumab (SIMPONI ARIA)

Patient Name:  
Date of Birth:

*Patient Identification*

**ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK ( ✓ ) TO BE ACTIVE**

**Treatment Start Date:** \_\_\_\_\_ **Allergies:** \_\_\_\_\_  
**Weight:** \_\_\_\_\_ **kg** **Height:** \_\_\_\_\_ **cm**

**REQUIRED ITEMS for all orders – necessary for insurance approval, scheduling, and patient safety**

- 1. FACE SHEET with complete INSURANCE information and patient CONTACT information**
- 2. Recent VISIT NOTE to support treatment (if not available in Epic)**
- 3. LAB RESULTS for any required prescreening (if not available in Epic)**
- 4. DIAGNOSIS CODE \_\_\_\_\_**
- 5. Patient NAME and DATE OF BIRTH on EVERY page faxed**

**GUIDELINES FOR ORDERING**

1. Send FACE SHEET and H&P or most recent chart note.
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.
3. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.

**PRE-SCREENING: (Results must be available prior to initiation of therapy):**

- Hepatitis B surface antigen and core antibody total test results scanned with orders.
- Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- Chest X-Ray result scanned with orders if TB test result is indeterminate.

**LABS:**

1. CBC with differential, Routine, ONCE, every visit, If on methotrexate or leflunomide
2. CMP, Routine, ONCE, every visit, If on methotrexate or leflunomide

**NURSING ORDERS:**

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. TREATMENT PARAMETER – Hold treatment and contact provider if patient has evidence of an active infection, if patient has a temperature greater than 100.4 degrees F, complains of symptoms or acute viral or bacterial illness, or if patient is taking antibiotics for current infection.
3. VITAL SIGNS – Prior to infusion and at the completion of the infusion.
4. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.



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**MEDICATIONS:**

Administer 2 mg/kg golimumab mixed in 100 mL of sodium chloride 0.9% over 30 minutes (dose will be rounded to nearest whole vial size).

1. Frequency (check all that apply)

- Initial doses: every 4 weeks for 2 treatments (week 0, 4)
- Maintenance doses: every 8 weeks thereafter (week 12 and beyond)

**OR**

- Maintenance doses: every \_\_\_\_ weeks thereafter (week 12 and beyond)

**INFUSION MONITORING/REACTION:**

Infusion Reaction. Acute Infusion and Hypersensitivity Medication Protocol will be used unless the provider selects the option below. If opting out, alternative orders must be included.

1. diphenhydramine 25 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. methylprednisolone 125 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. sodium chloride 0.9% 1000 mL IV, 200 mL/hr, AS NEEDED x 1 dose for alteration in hemodynamic status
6. albuterol 2.5 mg/3 mL nebule, AS NEEDED x1 dose for hypersensitivity reaction

Opting out of standard protocol. Alternative orders are attached, or deviations are documented:

\_\_\_\_\_

Patient will be treated at the following infusion location:

- St. Charles Outpatient Infusion Center  
2500 NE Neff Road, Bend, OR 97701  
Phone: (541) 706-5820 Fax: (541) 706-5825

By signing below, I represent the following:

- I am responsible for the care of the patient identified on this form
- I hold an active, unrestricted license to practice medicine
- I am acting within my scope of practice and authorized by law to order the medication described above for the patient identified on this form

**ALL ITEMS BELOW MUST BE COMPLETED TO BE A VALID PRESCRIPTION**

Signature: \_\_\_\_\_ License #: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_



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**Plan will expire 1 year after signature date at which time a new order will need to be placed**