Palmetto Infusion Services

MRN: _____

Phone: 800-809-1265 DOB: _____

STANDARD Simponi ARIA® (golimumab for infusion) **PLAN OF TREATMENT**

(Re)Certification Period from _____ to _____

NOTE: Patient is ***ineligible*** to receive Simponi Aria if receiving antibiotic for active infectious process (due to the possibility of developing a super-infection related to its effect on the immune status), or if he/she has a suspected infection.

Patient's Name _____ HT: _____ WT: _____ Allergies: _____

Diagnosis: ☐ 714.0 Rheumatoid Arthritis

☐ 714.2 Rheumatoid Arthritis with visceral or systemic involvement

Physician Office to Complete:

1. **Has your patient had failure, intolerance, or contraindication to conventional therapy?**
   □ Yes □ No
2. **If yes, please specify, treatment/medication tried and outcomes: _____**
   _____
3. **Is patient currently on methotrexate therapy? □ Yes □ No**

Obtain weight each visit. Vital signs baseline then 30 minutes post infusion for the first 3 treatments, then may discharge after infusion. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient for response to therapy. Supplies needed to complete prescribed therapy.

If adverse drug reaction, implement the Standing Adverse Reaction Protocol.

Drug:

Loading dose:

☐ **Simponi ARIA 2 mg/kg, infuse over 30 minutes, at week 0 and 4**

Maintenance Dose as follows:

☐ **Simponi ARIA 2mg/kg every 8 weeks**

Pharmacist to perform clinical drug monitoring

(no stamped signatures please)

Physician's Signature: _____ _____ Date: _____

(Dispense as written) (Substitution permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920

Patient should have a negative PPD within 6 months, documented absence of active TB, as well as documented Hep B surface antigen.

Does the patient have a history of (circle each): TB SOB Cough Night Sweats Fever Weight Loss None

Has the patient had recent exposure to TB or been out of the country in the past month? ☐ Yes ☐ No

Does the patient have a family history of TB? ☐ Yes ☐ No Chest X-Ray: ☐ Yes ☐ No Results: _____

Has the patient had a PPD test? ☐ Yes ☐ No Date _____ Results _____ **Palmetto must have copy on file**

Any previous treatment for TB? ☐ Yes ☐ No

Has patient received ***TNF therapy in past 6 months?*** ☐ Yes ☐ No Therapy: _____ Last date Received:_____

Hep B surface antigen drawn: ☐ Yes ☐ No Please fax results with referral along with PPD results