

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

# Simponi ARIA® (golimumab) Standard Plan of Treatment for Rheumatology

Rev 4.29.25

## PATIENT DEMOGRAPHICS:

Patient Name:	
Patient's Phone:	Address:
Date of Birth:	City, State, Zip:
Height in inches:	Weight: LB or KG Gender: Allergies: See list NKDA

## DIAGNOSIS: (PLEASE COMPLETE 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

M05._____ - Rheumatoid Arthritis with Rheumatoid factor	M06._____ - Rheumatoid Arthritis without Rheumatoid factor
L40.5_____ - Psoriatic Arthropathy	M45._____ - Ankylosing Spondylitis
- Other: _____	

## REQUESTED DOCUMENTATION:

## PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3	Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4	Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b>
5	<b>REQUIRED:</b> TB screening for new start	THERAPY:	
6	HBV screening/labs as required by payor		
			<b>Continue current order until insurance approved</b>

## MEDICATION ORDERS:

NOTE: Patient may be ineligible to receive golimumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new or worsening symptoms of CHF, new onset or deterioration neurological changes, and/or surgery

### PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

<b>IV</b>	Diphenhydramine	25mg	50mg	<b>PO</b>	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg		Other:	Famotidine	20mg	40mg	
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg	
	Other:					Fexofenadine	60mg	180mg	
					Cetirizine	10mg			
					Loratadine	10mg			
					Other:				

## MEDICATION/DOSE:

Simponi ARIA® (golimumab) 2 mg/kg per 100 ml NS given IV to infuse over at least 30 minutes

## FREQUENCY:

Induction: Given at 0 week and 4 weeks, and then every 8 weeks thereafter

Maintenance: Given every 8 weeks

Other: \_\_\_\_\_

## SPECIAL/OTHER LAB ORDERS:

\_\_\_\_\_

\_\_\_\_\_

Prescriber confirms that the patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment. Prescriber to monitor patient for symptoms of HBV and TB infection and reactivation as clinically appropriate.

Refills x 12 months unless noted otherwise here:

## NURSING ORDERS:

Start PIV/Access CVC

Flush device per facility standard flushing procedure

Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

## ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website.

## PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

## PRESCRIBER SIGNATURE: (No stamp signatures)

DATE:

Dispense as written/Brand medically necessary	Substitution permitted