Palmetto INFUSION®

Phone: 1-800-809-1265 Fax: 1-866-872-8920

| Referral Status: | | MRN: |
|---|---|---|
| ☐ New referral | ☐ Order change | ☐ Order Renewal |
| Patient preferred clinic: | | |

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

## PATIENT DEMOGRAPHICS:

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

## DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD 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:

| | |
|---|---|
| 1 | Insurance information |
| 2 | Most recent History & Physical |
| 3 | Full medication list |
| 4 | Tried and failed therapies |
| 5 | **REQUIRED:** TB screening for new start patients |
| 6 | HBV screening/labs as required by payor |

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

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:

LAST INFUSION DATE:

NEXT INFUSION DATE:

**IF ORDER CHANGE:**

☐ **Continue current order until insurance approved**

## 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**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **IV** | Diphenhydramine | ☐ 25mg | ☐ 50mg | | | | | |
| | Methylprednisolone | ☐ 40mg | ☐ 125mg | ☐ Other: | | | | |
| | Famotidine | ☐ 20mg | ☐ 40 mg | | | | | |
| | Other: | ☐ | | | | | | |

| | | | | | |
|---|---|---|---|---|---|
| **PO** | Acetaminophen | ☐ 325mg | ☐ 500mg | ☐ 650mg | ☐ 1000mg |
| | Famotidine | ☐ 20mg | ☐ 40mg | | |
| | Diphenhydramine | ☐ 25mg | ☐ 50mg | | |
| | 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:

## LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

## ADVERSE REACTION & ANAPHYLAXIS ORDERS:

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

## 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 | |