

Golimumab (Simponi ARIA) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one and complete the 2nd and 3rd digits to complete the ICD-10 code):

- M05.____ Rheumatoid Arthritis with Rheumatoid factor
- M06.____ Rheumatoid Arthritis without Rheumatoid factor
- L40.5____ Psoriatic Arthropathy
- M45.____ Ankylosing Spondylitis
- Other: ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

- None
- Acetaminophen 650 mg PO
- Diphenhydramine: Dose: 25 mg 50 mg Route: PO or IVP
- Methylprednisolone: Dose: 40 mg or 125 Route: IVP
- Famotidine: Dose: 20 mg Route: PO or IVPB
- Other (include drug, dose, and route): _____

Drug Orders:

- Golimumab (Simponi ARIA) (J1602) 2 mg/kg per 100 mL Sodium Chloride 0.9% IV to infuse over 30 minutes
- Frequency: Induction: Weeks 0 and 4 then every 8 weeks thereafter
 - Maintenance: every 8 weeks
 - Other: _____
- Order Duration: Six months unless otherwise specified (Other: _____)
- Monitoring: post infusion monitoring to occur for 30 minutes after the first 3 treatments

Lab Orders:

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ Date: _____

Physician Name: _____ Phone: _____

Pre-Screening Requirements:

- Provide TB screening results (PPD or QuantiFERON Gold Test) prior to start of therapy and within last 12 months
- Provide Hepatitis screening (Hepatitis B Surface Antigen) prior to start of therapy and within last 12 months

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received golimumab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____
and the last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Florence: 843-777-6001 (Fax)

843-777-4655 (Phone)