Place Sticker Here

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.

Seacoast: 843-366-2224 (Fax)

843-366-3626 (Phone)