

SIMPONI ARIA (GOLIMUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET

| | Pati | ient Information | | | | |
|---|---|---|---|--|--|--|
| Patient Name: | | | Date: | | | |
| DOB: | | | Height: | 🗆 inches 🕒 cm | | |
| Allergies: | | | Weight: | 🗆 lbs 🖵 kg | 🗆 lbs 🖵 kg | |
| Primary Diagnosis | | | | | | |
| Diagnosis ICD-10 Diagnosis | | | ICD-10 | | ICD-10 | |
| Rheumatoid arthritis | M45 | Rheumatoid arthritis with rheumatoid factor, unspecif | | unspecified | M05.9 | |
| Rheumatoid arthritis, unspecified | M06.9 | Rheumatoid arthritis w/o rheumatoid factor, unspecified | | unspecified | M06.00 | |
| Juvenile rheumatoid polyarthritis (seronegative) | M08.3 | Other juvenile arthrit | Other juvenile arthritis, unspecified site | | M08.80 | |
| Psoriatic Arthritis | L40.52 | Other: | | | | |
| Ankylosing Spondylitis | M45 | | | | | |
| Medication Order | | | | | | |
| Simponi Aria (Golimumab): 2mg/kg IV at weeks 0,4 and then every 8 weeks x 1 year (initial dosing) 2mg/kg IV every 8 weeks x 1 year Other Infusion will be administered over 30 minutes Skilled nursing to assess and administer and/or teach self-administration where appropriate via access device as indicated below. Nursing will provide ongoing support as needed. | | | | from date signature indicated | Refills x one year from date of signature unless indicated below Refills | |
| Ancillary Orders | | | | | | |
| | | | | | | |
| Pre-medications: Diphenhydramine: 25mg PO 30 min pre-infusion Acetaminophen: 650mg PO 30 min pre-infusion Famotidine: 20 mg PO x1 dose Other pre-meds: Refill x one year | | Implanted VAI post-lab draw. CVAD: NS 5 to | 1-3 mL before/after use D: NS 5 to 10 mL before/ Heparin (100 unit/mL) 3 10 mL before/after use hits/mL) 3 to 5 mL final f par | after use and 10 mL 3 to 5 mL final flush and 10 mL post-lab dr | 'aw | |
| Diphenhydramine: 25mg PO 30 min pre-infusion Acetaminophen: 650mg PO 30 min pre-infusion Famotidine: 20 mg PO x1 dose Other pre-meds: | pack: Adult: | Peripheral: NS Implanted VAI post-lab draw. CVAD: NS 5 to Heparin (10 ur Refill x one yee 0.3mg Children: 0.15 mg | D: NS 5 to 10 mL before/ Heparin (100 unit/mL) 3 10 mL before/after use hits/mL) 3 to 5 mL final f har | after use and 10 mL 3 to 5 mL final flush and 10 mL post-lab dr | 'aw | |
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Prescriber Signature: ____

Date: _____

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