

Golimumab (Simponi Aria®) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.

Fax completed form, insurance information and clinical documentation to 414-260-7368.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code(s): _____

Is this the first dose? Yes - Date of first dose: _____ No - Date of next dose: _____

Hepatitis B Status: Titer Date: _____ Positive Negative

PPD (negative) – date: _____ Active TB Unknown

TB Status Last chest x-ray – date: _____ Other _____

Past positive TB infection, course taken: _____

Golimumab (Simponi Aria®) Prescription

Golimumab (Simponi Aria®) refill as directed x 1 year

Initial Dose:

- Infuse 2 mg/kg IV over 30 minutes on Weeks 0 and 4.
 Other: _____

Maintenance Dose:

- Infuse 2 mg/kg IV over 30 minutes every 8 weeks.
 Other: _____

Ancillary Orders

Anaphylaxis Kit

- Treat per Froedtert Home and Specialty Infusion protocol.
 Other: _____

Medication Orders

- Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may use own supply or patient may decline.
 Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may use own supply or patient may decline.
 Methylprednisolone 40 mg IV push 20 minutes prior to infusion.
 Other: _____

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

- Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.
 Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab draw.

Lab Orders

- No labs ordered at this time.
 Other: _____

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature _____ Date _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____



Original - Medical Records

Froedtert Home and Specialty Infusion
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