

## Golimumab (Simponi ARIA®)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVE Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

<b>Patient Name:</b> _____ <b>Patient Address:</b> _____ <b>Patient Phone Number:</b> _____ <b>Date of Birth:</b> ____/____/____ <b>Weight:</b> ____ kg <b>Height:</b> ____ cm <b>Allergies:</b> _____	<b>Primary Insurance:</b> _____ <b>Member ID:</b> _____ <b>Secondary Insurance:</b> _____ <b>Member ID:</b> _____																
<p style="text-align: center;"><b>Diagnosis</b></p> <input type="checkbox"/> Rheumatoid arthritis with rheumatoid factor (M05) <input type="checkbox"/> Ankylosing spondylitis (M45) <input type="checkbox"/> Other rheumatoid arthritis (M06) <input type="checkbox"/> Arthropathic psoriasis, unspecified (L40.50) <input type="checkbox"/> Juvenile psoriatic arthritis (L40.54) <input type="checkbox"/> Psoriatic spondylitis (L40.53) <input type="checkbox"/> Other Diagnosis Code (ICD-10): _____ <input type="checkbox"/> Other Indication: _____ Target start date: _____	<table style="width: 100%;"> <tr> <th style="text-align: left; width: 60%;">Labs</th> <th style="text-align: left; width: 40%;">Frequency</th> </tr> <tr> <td><input type="checkbox"/> BMP</td> <td><input type="checkbox"/> Every infusion</td> </tr> <tr> <td><input type="checkbox"/> CMP</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> CBC w/ diff</td> <td></td> </tr> <tr> <td><input type="checkbox"/> CBC w/o diff</td> <td></td> </tr> <tr> <td><input type="checkbox"/> CRP</td> <td></td> </tr> <tr> <td><input type="checkbox"/> ESR</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> </table>	Labs	Frequency	<input type="checkbox"/> BMP	<input type="checkbox"/> Every infusion	<input type="checkbox"/> CMP	<input type="checkbox"/> Other: _____	<input type="checkbox"/> CBC w/ diff		<input type="checkbox"/> CBC w/o diff		<input type="checkbox"/> CRP		<input type="checkbox"/> ESR		<input type="checkbox"/> Other: _____	
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<input type="checkbox"/> Other: _____																	
Previously tried and failed therapies (include dates): _____																	
<p><b>Golimumab (Simponi ARIA®)</b> in 100 mL 0.9% sodium chloride infused over 30 minutes</p> <p><b>Nursing note:</b> Do not infuse in the same intravenous line with other agents. Use only an infusion set with an in-line low protein binding filter (pore size 0.22 micrometer or less)</p>																	
<p style="text-align: center;"><b>Dose</b></p> <input type="checkbox"/> 2 mg/kg <input type="checkbox"/> ____ mg/kg <input type="checkbox"/> ____ mg	<p style="text-align: center;"><b>Frequency</b></p> <input type="checkbox"/> At weeks 0, 4 <input type="checkbox"/> Every 8 weeks <input type="checkbox"/> Every ____ weeks  Date of last infusion: ____/____/____																

<b>Pre-Medications and Pre-Protocol</b> (ordered at physician discretion)	<input type="checkbox"/> Acetaminophen 650 mg PO once <input type="checkbox"/> Loratadine 10 mg PO once <input type="checkbox"/> Diphenhydramine once <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Famotidine 20 mg IV once <input type="checkbox"/> Hydrocortisone 100 mg IV once <input type="checkbox"/> Methylprednisolone 125 mg IVP once <input type="checkbox"/> Other: _____	<b>Hydration</b> <input type="checkbox"/> LR <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> Other _____  _____ mL at _____ mL/hr <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> Following
<b>Flushing Protocol</b> <i>as needed for line care</i>	<input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL	<input type="checkbox"/> Heparin 100 Units/mL <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL
<b>Hypersensitivity Panel</b> Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	<ul style="list-style-type: none"> <li>• <b>Sodium chloride</b> 0.9% bolus 500 mL once as needed for hypotensive management (SBP &lt;90mmHg)</li> <li>• <b>Acetaminophen</b> 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping</li> <li>• <b>Albuterol</b> 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses</li> <li>• <b>Albuterol HFA</b> inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea</li> <li>• <b>Epinephrine</b> injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses</li> <li>• <b>Famotidine</b> injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure</li> <li>• <b>Diphenhydramine</b> injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom</li> <li>• <b>Diphenhydramine</b> injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure</li> <li>• <b>Hydrocortisone</b> sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure</li> </ul>	
<div> <div> Provider Name: _____  Attending Physician Name: _____  Office Phone Number: _____    <i>Note: This order is valid for 12 months from date of physician signature.</i> </div> <div> Provider Signature: _____  Provider NPI: _____  Office Fax Number: _____ </div> </div>		