Oregon Medical Group Infusion Center

1007 Harlow Road, Springfield, Oregon 97477
Phone: 541-741-0387 Fax: 541-242-4634

Golimumab (Simponi Aria) Orders

Name: ______________________________________ DOB: _______________________________

Diagnosis/Indication: ___________________________ ICD-10 Code: ________________________

1. Vital signs: Initial, Q 15-30 minutes, PRN
2. Peripheral IV site with saline lock, may use existing PICC line or port-a-cath if available.
3. Administer 2 mg/kg Simponi ARIA mixed in 100mL 0.9% Normal Saline over 30 minutes.
4. Frequency (check all that apply)

   ☐ Initial doses: every 4 weeks for 2 treatments (week 0, 4)

   ☐ Maintenance doses: every 8 weeks thereafter (week 12 and beyond)

   OR

   ☐ Maintenance doses: every ____ weeks thereafter (week 12 and beyond)
5. Pre-medications to be given 30 minutes prior to infusion (optional)

   ☐ OMG Infusion Center Pre-Medication Protocol

   OR

   ☐ Administer the following routine pre-medications prior to each infusion
   - ☐ Acetaminophen (Tylenol) 650 mg PO
   - ☐ Antihistamine (Select one)
     - ☐ Diphenhydramine (Benadryl) 25 mg PO
     - ☐ Diphenhydramine (Benadryl) 25 mg IV infusion over < 10 mins
     - ☐ Loratadine (Claritin) 10 mg PO
   - ☐ Methylprednisolone (Solu-Medrol) 40 mg IV infusion over < 10 min, not to exceed 50 mg/min
   - ☐ Methylprednisolone (Solu-Medrol) 100mg IV infusion over < 10 min, not to exceed 50mg/min
   - ☐ Ondansetron 4 mg IV **OR** ☐ Ondansetron 8 mg IV

   ☐ Other: ____
6. For infusion reaction (**Must select one to be considered a complete order**)

   ☐ Acute Infusion Reaction Protocol

   ☐ Other ____

Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order (non-OMG providers). A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order (non-OMG providers).

Provider Signature: ____ Date: _____________
(NO PROVIDER STAMPS) (Orders expire after 365 days)

Provider's Printed Name: _______________________________________Time: ____________