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| ADULT AMBULATORY INFUSION ORDER  **Golimumab (Simponi Aria)** |   **NAME:** **BIRTHDATE:** *Affix Patient Identification Label Here* |
| **ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (**  **) TO BE ACTIVE.**  |

**Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

Provider Information

\***Please fax a copy of the** □Demographics □ Insurance Information □ Current Lab Results

**following patient information**: □ H & P Relevant to Diagnosis □ Last infusion note □ Current Medications

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Information

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ lbs/kg Height: \_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_\_

 Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hep B Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ □ Copy Attached

Has patient had any immunizations in the last 3 months? □ Yes □ No

TB TEST

Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Test Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_ □ Copy Attached

MC2685 (04/22

Pre-medications:

Diphenhydramine: □ IV □ 50mg

Acetaminophen: □ PO □ 1000 mg

Solu-Medrol: □ IV □ 1000 mg

Other: □ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No Pre-Medications

□ 30 minutes wait time following pre-medications

Labs:

□ CBC w/diff □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ CMP □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other: \_\_\_\_\_\_\_\_\_\_□ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No labs needed

 **Simponi Aria (golimumab) IV Dosage:**

* Simponi Aria (golimumab) in 0.9% NS 100 ml IV infusion with a 0.22 micron filter

**Dose: 2 mg/kg = Total Dose: \_\_\_\_\_\_\_\_ mg.**

**Frequency:**

 **□ Every 0, 4, and every 8 weeks**

 **□ Every \_\_\_\_\_\_\_\_\_\_\_ weeks**

**Infusion Duration: 30 minutes**