GOLIMUMAB (SIMPONI ARIA®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

YOUR INTELLIGENT HEALTH COMPANY.
UBACARE

Patient Name:			**Date of Birth:**	
Address:				
Patient Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs. ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Is this the first dose?	☐ Yes – date of first dose: ☐ No – date of next dose due:	**Hepatitis B Status:**	Titer Date: ☐ Positive ☐ Negative

TB Status:	☐ PPD (negative) – date:	☐ Active TB
	☐ Last chest x-ray – date:	☐ Unknown
	☐ 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

➔ Required per Option Care policy – please complete Anaphylaxis Physician Order (FR-PC-036) provided.

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 Flush Orders

- ☐ Peripheral: NS 2 to 3 mL pre-/post-use.
- ☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

- ☐ No labs ordered at this time.
- ☐ Other:

Skilled nurse to administer doses intravenously in the home or alternate care setting. 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:**

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State: **Zip:**	**Office Contact:**	

