Golimumab
(SIMPONI ARIA)

6955 Foothill Blvd, Suite 67A, Oakland, CA, 94605
Phone: (510) 878-9528 | Fax: (510) 969-5840 | Email: referrals@totalinfusion.com

Name: ______________________________
DOB: ______________ Phone: ______________
Gender: ☐ Male ☐ Female
Allergies: ______________________________

DIAGNOSIS (ICD-10 code required):

☐ _______ Rheumatoid Arthritis (RA)
☐ _______ Psoriatic Arthritis (PsA)
☐ _______ Ankylosing Spondylitis (AS)
☐ _______ Other: ____________________

PROVIDER REMINDERS:

- All orders with a ☑ will be placed unless otherwise noted
- Screen for viral hepatitis prior to use
- Ensure baseline PPD or quantiFERON-TB Assay for latent TB
- Do not combine with tumor necrosis factor (TNF) agents, Abatacept, or Anakinra
- Ensure all immunizations are current before initiating therapy
- CBC at baseline and every 8 weeks

TREATMENT CRITERIA:

Hold Golimumab (SIMPONI ARIA) if:

- Temperature **GREATER THAN** 100 degrees F
- Complains of symptoms of acute viral or bacterial illness
- Taking antibiotics for current infection
- *Initial dose only:* Unable to verify negative TB and HBV results

Notify Provider If:

- Patient presents with a cough that lasts more than three weeks, loss of appetite, unintentional weight loss, fever, chills, or night sweats

Nursing Considerations:

- Ensure CBC has been drawn within the last 8 weeks, if not, proceed with infusion and instruct patient to have labs drawn today
- Monitor for adverse reaction, including vital signs and pulse ox, at the end of infusion and 30 minutes post infusion
- Patient may forgo 30 minute observation period if no adverse reaction after the first three infusions

Premedications

☐ **No routine premeditations necessary.**
☐ ______________________________
☐ ______________________________

Medications

Patient Weight ______kg **(REQUIRED)**

Infuse **Golimumab (SIMPONI ARIA)** Intravenously over 30 minutes using an in-line, sterile, non-pyrogenic, low-protein binding filter (pore size 0.22micrometer or less).

Dose/Frequency:

☐ 2mg/kg every 4 weeks x 2 doses, then every 8 weeks thereafter

☐ **IV LINE CARE** per Nursing Policy
☐ **INFUSION REACTION MEDICATIONS** per Standardized Procedures
☐ **TREATMENT ORDER WEIGHT** will be utilized for the duration of the order. Patient will be weighed prior to every treatment. Prescriber will be notified of weight change greater than 10% from baseline weight.

Special Instruction(s):

Provider Signature ______________ Date ______________ Email ______________
Printed Name ______________ Phone ______________ Fax ______________
Office Contact ______________ Phone ______________ Email ______________