

SIMPONI ARIA (GOLIMUMAB) IV INFUSION ORDER FORM

Full Name: Date of Birth:

Phone Number: Email Address:

Address:

Weight: lb/kg Allergies: ☐ NKDA ☐

Treatment Status: ☐ New ☐ Continued **Last Treatment Date:**

DIAGNOSIS (ICD-10 SELECTION)

☐ M06.9 – Rheumatoid arthritis, unspecified ☐ M08.3 – Juvenile idiopathic arthritis

☐ L40.53 – Psoriatic arthritis

☐ M45.9 – Ankylosing spondylitis

☐ Other: ☐ ICD-10 CODE:

INFUSION ORDER

☐ 2 mg/kg IV in 100 mL 0.9% sodium chloride

☐ Induction: Week 0, Week 4, then every 8 weeks

☐ Maintenance: Every 8 weeks

☐ Infuse over 30 minutes using 0.22-micron or smaller in-line filter

☐ Flush with 0.9% sodium chloride post-infusion

☐ Observation: ☐ 30 minutes post-infusion

☐ Refills: ☐ None ☐ 12 Months ☐ Other:

LINE USE & ACCESS

☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☐ Flush per standard injection protocol

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☒ Kaison Infusion Center Protocol (www.kaisoninfusion.com)

☐ Other - please fax preferred reaction orders to (405) 237-6305

PREMEDICATION (OPTIONAL)

☐ Acetaminophen:	☐ 500 mg	☐ 650 mg	☐ 1000 mg	☐ PO
☐ Diphenhydramine:	☐ 25 mg	☐ 50 mg	☐ PO	☐ IV
☐ Methylprednisolone:	☐ 40 mg	☐ 125 mg	IV	☐
☐ Cetirizine:	☐ 10 mg	☐ PO		
☐ Hydrocortisone:	☐ 100 mg	☐ IV		
☐ Other:	Dose:	Route:		

LABORATORY MONITORING

☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ TB Screening ☐ Hepatitis B Panel ☐ Other:

Frequency: ☐ Prior to first dose ☐ Monthly ☐ Other:

☐ Physician office will order labs only

CLINICAL DOCUMENTATION CHECKLIST

☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list

☐ Documentation of prior DMARD or biologic therapy ☐ TB and Hepatitis B screening results

ORDERING PROVIDER & DEMOGRAPHICS

Name: NPI: LICENSE #:

Contact: Phone: Fax:

Email: Signature: Date: