## ADULT AMBULATORY INFUSION ORDER

**Golimumab (SIMPONI ARIA) Infusion**

### ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

<table>
<thead>
<tr>
<th>Weight:</th>
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<td>kg</td>
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### Allergies: ___________________________________________________________

### Diagnosis Code: ___________________________________________________

### Treatment Start Date: ___________  Patient to follow up with provider on date: _________________

**This plan will expire after 365 days at which time a new order will need to be placed**

### GUIDELINES FOR ORDERING

1. Send FACE SHEET and H&P or most recent chart note.
2. 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.
3. 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.

### PRE-ScreenING: (Results must be available prior to initiation of therapy):

- [ ] Hepatitis B surface antigen and core antibody total test results scanned with orders.
- [ ] Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.

### LABS:

1. CBC with differential, Routine, ONCE, every visit, If on methotrexate or leflunomide
2. CMP, Routine, ONCE, every visit, If on methotrexate or leflunomide

### NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. Infusions to be scheduled at weeks 0 and 4, then every 8 weeks thereafter.
3. Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the completion of the infusion.
4. If Hypersensitivity or Infusion related events develop the infusion should be interrupted temporarily and the patient should be carefully assessed. Infusion related side effects may consist of: Temp greater than 38.5, rigors, SBP greater than 30 mmHg decrease from baseline, mucosal or respiratory (congestion/edema) distress.

### MEDICATIONS: (check all that apply)

- [ ] golimumab (SIMPONI ARIA) 2 mg/kg diluted to 100 mL in 0.9% NaCl, intravenous, ONCE
  - [ ] Initial doses: Every 4 weeks for 2 treatments (week 0, 4)
  - [ ] Maintenance doses: Every 8 weeks thereafter (week 12 and beyond)

Infuse over 30 minutes. Infuse with in-line low protein-binding 0.22 micron filter. Do not infuse in the same line with other medications.
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AS NEEDED MEDICATIONS:
- ☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for headache, fever, chills or malaise
- ☐ diphenhydramine (BENADRYL) capsule, 50 mg, oral, EVERY 4 HOURS AS NEEDED for itching

HYPERSENSITIVITY MEDICATIONS:
1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (Policy HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x1 dose for hypersensitivity or infusion reaction
3. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
   - EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity or infusion reaction

By signing below, I represent the following:
I am responsible for the care of the patient (who is identified at the top of this form);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ (check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon);
My physician license Number is # __________________ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: ___________________________ Date/Time: ________________________
Printed Name: ___________________________ Phone: ___________________________ Fax: ___________________________
OLC Central Intake Nurse:
Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient’s preferred clinic location:

- **Beaverton**
  OHSU Knight Cancer Institute
  15700 SW Greystone Court
  Beaverton, OR 97006
  Phone number: 971-262-9000
  Fax number: 503-346-8058

- **NW Portland**
  Legacy Good Samaritan campus
  Medical Office Building 3, Suite 150
  1130 NW 22nd Ave.
  Portland, OR 97210
  Phone number: 971-262-9600
  Fax number: 503-346-8058

- **Gresham**
  Legacy Mount Hood campus
  Medical Office Building 3, Suite 140
  24988 SE Stark
  Gresham, OR 97030
  Phone number: 971-262-9500
  Fax number: 503-346-8058

- **Tualatin**
  Legacy Meridian Park campus
  Medical Office Building 2, Suite 140
  19260 SW 65th Ave.
  Tualatin, OR 97062
  Phone number: 971-262-9700
  Fax number: 503-346-8058

Infusion orders located at: [www.ohsu knight.com/infusionorders](http://www.ohsu knight.com/infusionorders)