Weight: _________ kg  Height: _________ cm

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. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. 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.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

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. VITAL SIGNS – Prior to infusion and at the completion of the infusion.
3. Infusions to be scheduled at weeks 0 and 4, then every 8 weeks thereafter.

MEDICATIONS: (check all that apply)

golimumab (SIMPONI ARIA) 2 mg/kg in sodium chloride 0.9%, intravenous, ONCE, over 30 minutes

- ☐ Initial doses: Every 4 weeks for 2 treatments (week 0, 4)
- ☐ Maintenance doses: Every 8 weeks thereafter (week 12 and beyond)

AS NEEDED MEDICATIONS:
1. acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for headache, fever, chills or malaise
2. diphenhydroAMINE (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 (OHSU 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 x 1 dose for hypersensitivity or infusion reaction

3. epinephrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 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

5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 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: ________________
Central Intake:  
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