Ascension St. Vincent's
Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Golimumab (Simponi) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	Weight	_____ kg	Allergies	☐ NKDA	☐ List: _____

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Ankylosing Spondylitis ☐ Other: _____	☐ M05.89, M05.9, M06.00, M06.9 ☐ L40.50, L40.53 ☐ M45.____ ☐ K51.____ ☐ Other: _____	☑ J1602	☑ CPT Code: _____

Labs (prior to scheduling first infusion)	Other Labs:
☑ TB test, Hepatitis B Surface Antigen Level and Hepatitis B Core Total Antibody Level Test	☐ _____ ☐ _____

Nursing Orders	Pre-medications (not required)	
☑ Discharge patient when stable and meets protocol criteria	☐ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
Emergency/Anaphylaxis Order	☐ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☑ Follow standard orders for management of allergies and anaphylaxis reactions	☐ Dexamethasone 20 mg IV, once	☐ Other: _____
	☐ Ondansetron 4 mg IV, once	☐ Other: _____

Medication Orders

	Medication	Route	Dose	Frequency	Select Treatment Type
☑	Golimumab	IVPB	2 mg/kg over 30 mins	Once	☐ Initial: Every 4 weeks x 2 doses ☐ Maintenance: Every 8 weeks for ____ dose(s) ☐ Give at week 0 and 4, then every 8 weeks for_____ doses ☐ Other: _____

Order Comments: Infuse through a ≤ 0.22 micron, low protein binding inline filter. Dilute in NS or ½ NS to a total volume of 100 mL.
*Pharmacy may adjust dose +/- 10% of calculated dose per Pharmacy and Therapeutics Committee approved protocol.
Administration Instructions: Do not administer golimumab concomitantly in the same IV line as other agents.

Infusion Center Staff Please fax infusion records or discharge summary to: **Fax Number _____**

Provider Signature		Date	
Provider Printed Name			