Novella Infusion

Patient Name:
DOB:
Date of Last Infusion
Insurance:

Clinic Location:
Merrimack, NH ☐
Concord, NH ☐

Golimumab (Simponi Aria®) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):	Weight: _____
_____ (ICD-10) Psoriatic Arthritis _____ (ICD-10) Ankylosing Spondylitis _____ (ICD-10) Rheumatoid Arthritis	
_____ (ICD-10) Other: _____	
TB screening result:_____ HBV screening result: _____(please include copy of results with order)	

Nursing:

- Hold infusion and notify provider for fever, signs or symptoms of illness or active infection, or planned/recent surgical procedures
- If infusion-related reaction occurs, stop infusion, notify provider and follow Hypersensitivity Reaction Management Protocol as clinically indicated.

Dose: Administer golimumab 2 mg/kg = _____ mg in 100 mL 0.9% or 0.45% sodium chloride using an in-line, sterile, non-pyrogenic low-protein binding **filter** (pore size 0.22 micron or less) over a period of 30 minutes.

Frequency (chose one):

☐ On weeks 0, 4, then every 8 weeks

☐ Every 8 weeks

☐ Every _____ weeks

Additional Orders:

Provider name (print): _____ Date:_____

Provider signature: _____ Time: _____

Revised 6/1/18

(order valid for one year unless otherwise indicated)