Patient Name: _____ DOB: ___/___/_____ Date of Last Infusion: ___/___/_____
Height_____ Weight_____

Infusion Location: (state and Site) _____

Simponi Aria® (golimumab) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Psoriatic Arthritis (ICD-10)
_____ Ankylosing Spondylitis (ICD-10)
_____ Rheumatoid Arthritis (ICD-10)
_____ Other: _____ (ICD-10)

Nursing Orders:

- Hold infusion and notify provider for:
  - Abnormal vital signs, Fever, neurological changes, signs/symptoms of illness/active infection
  - Planned/recent surgical procedures or recent live vaccinations
- If an infusion-related reaction occurs, stop infusion and initiate Hypersensitivity Reaction Management Protocol as clinically indicated.

Lab Orders:	❑ CMP	❑ Other_____
❑ CBC with diff	❑ LFT	❑ Other_____

Administer golimumab 2mg/kg x (current weight) _____ kg = _____ mg
in 100 mL 0.9% sodium chloride. Administer 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: _____

Reviewed 6/29/2022. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.