



**ADULT AMBULATORY INFUSION ORDER**  
**3/2023**  
**Golimumab (SIMPONI ARIA) Infusion**

**NAME:**  
**BIRTHDATE:**  
**INSURANCE:**  
**PROVIDER NAME:**  
**CLINIC NAME and Phone number:**

Patient identification

**Weight:** \_\_\_\_\_ **kg**    **Height:** \_\_\_\_\_ **cm**    **Allergies:** \_\_\_\_\_    **Diagnosis Code:** \_\_\_\_\_

**Treatment Start Date:** \_\_\_\_\_

**\*\*If treatment not started within 90 days, new orders with updated date/signature will be required. Otherwise, orders are valid for 1 year from signature date.\*\*** **GUIDELINES FOR ORDERING:**

- 1) Patient name and date of birth must be on EACH page of this order form. This form will be returned if any left blank.
- 2) Send FACE SHEET and complete copy of INSURANCE information. Send H&P or most recent chart note, must be within the past 12 months.
- 3) Send a copy of related lab results if not available for review in Epic.

**REQUIRED Pre-screening labs:** (Results must be available prior to initiation of therapy, attach copy if not available in Epic)

- QuantiFERON Gold TB.

**Recommended Pre-screening labs:** Send any applicable results from list below.

- Hepatitis C Antibody
- Hepatitis B surface antigen

**Optional LABS to be done at infusion appointments:** (select all that apply)

- Comprehensive Metabolic Set, Routine, every \_\_\_\_\_
- CBC with differential, Routine, every \_\_\_\_\_
- Sedimentation Rate, Routine, every \_\_\_\_\_
- QuantiFERON Gold, Routine, annually.

**MEDICATION & DOSE:**

- Golimumab (SIMPONI ARIA)** 2mg/kg in sodium chloride 0.9% 100ml IVPB, infuse over 30 minutes. Use 0.22-micron filter for administration.

**FREQUENCY:** (must check & complete one)

- Induction AND Maintenance doses:**  
To infuse on week 0 & week 4. After week 4, maintenance doses to be given every \_\_\_\_\_ weeks.

**OR**

- Maintenance doses ONLY:** *To continue treatment with ongoing maintenance orders. If infusions received elsewhere date of last infusion here: \_\_\_\_\_.* Give every \_\_\_\_\_ weeks.

**AS NEEDED MEDICATIONS:**

- Sodium chloride 0.9% (NS) bolus 250 ml, Flush before and after IV medication(s) and as needed with NS.

**Standard included Nursing Orders:**

- Confirm that prescreening tests are normal or have been addressed by Licensed Independent Practitioner. Notify provider before starting infusion if patient has signs of active infection or history of reaction to previous infusion that has not been addressed by LIP.
- Remind patient to avoid live vaccines.
- Vital signs: Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion.
- Insert peripheral IV if no iv access.
- May use/access CVC line and give 500 units (5ml) heparin injection for central line care.
- If hypersensitivity or infusion reactions develop, temporarily hold the infusion, and notify provider immediately. Include hypersensitivity reaction order set. (See attached form).



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#### **HYPERSENSITIVITY INFUSION REACTION ORDERS**

##### **STOP infusion if:**

**MILD REACTION:** Localized pruritus, rhinitis, localized rash, fever greater than 38 degrees C.

1. Stop infusion and maintain IV access with NS line.
2. Notify MD of symptoms and infusion reaction orders initiated.

**MODERATE REACTION:** Generalized pruritus, generalized flushing, rash, back pain, mild dyspnea, chills, hypotension with SBP less than 90 mmHg or greater than 20% decrease in SBP.

1. Stop infusion, but do not discard infusion bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Maintain IV access with NS line.
3. Place patients in a supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.

**SEVERE REACTION:** Respiratory distress (bronchospasm, stridor, wheezing, persistent cough, respiratory depression, cardiac arrhythmia, chest pain, generalized urticaria (hives), syncope, gastrointestinal symptoms (abdominal pain, N/V, diarrhea), hypotension SBP less than 80 mmHg, face/throat/tongue swelling, shock, loss of consciousness.

1. Stop infusion, but do not discard bag/bottle unless instructed by MD that therapy is to be discontinued.
2. Stay with patient and have another nurse notify MD of symptoms and infusion reaction orders initiated.
3. Place patients in supine position with lower extremities elevated unless respiratory distress or nausea/vomiting.
4. Maintain airway.
5. Maintain IV access with NS line.
6. Inpatients: Activate code blue for loss of blood pressure, pulse, or consciousness.

##### **MEDICATIONS:**

- Acetaminophen (TYLENOL) tablet 650 mg, Oral, EVERY 4 HOURS PRN, Pain, Other, Mild reaction. Starting when released.
- Diphenhydramine (Benadryl) injection, 25 mg, Intravenous, EVERY 15 MIN PRN, Moderate or severe reaction, may repeat x1. Starting when released, For 2 doses.
- Methylprednisolone sodium succinate (solu-MEDROL) 62.5mg/ml injection, 125 mg, Intravenous, ONCE PRN, Severe reaction. Starting when released, For 1 dose. Mix with 2 mL provided diluent to make 62.5 mg/mL.
- Famotidine (PEPCID) injection 20 mg, Intravenous, ONCE PRN, Moderate reaction, or anaphylaxis, starting when released. Dilute 2 mL of famotidine with 8 mL of normal saline to a final concentration of 2 mg/mL. Administer ordered dose over a period of at least 2 minutes.
- Albuterol 90 mcg/puff inhaler 2 puff, Inhalation, ONCE PRN, Severe reaction p. Starting when released, For 1 dose. Shake well. Use with spacer.
- Start oxygen. For *MODERATE* Reaction: Start 2 liters O2 per nasal cannula as needed for SpO2 less than 93%. For *SEVERE* Reaction: Start continuous pulse oximetry. Administer 6 to 8 liters per minute (LPM) via face mask, or up to 100% oxygen to maintain oxygen saturation greater than 90%.



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- EPINEPHrine 1 mg/mL injection 0.3 mg. Intramuscular, EVERY 5 MIN PRN, Anaphylaxis. Starting when released, For 3 doses. Administer in the anterior lateral thigh using 1 - 1.5-inch needle for airway obstruction symptoms and/or hypotension.
- Sodium chloride 0.9% (NS) infusion 500ml. At 500 mL/hr., Intravenous, PRN, Moderate reaction, or anaphylaxis. Starting when released. Run wide open to gravity.

**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.

**My physician license Number is #** \_\_\_\_\_ and I am acting within my scope of practice and authorized by law to order infusion of the medications and blood products described above for the patient identified on this form.

**Provider's printed name:** \_\_\_\_\_

**Provider's signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Please complete the following intake questions.**

**Mobility status**

- Independent
- Walker
- Wheelchair
- Fully dependent

**Bariatric needs**

- Yes, briefly describe \_\_\_\_\_
- No

**Transportation concerns**

- Yes, briefly describe \_\_\_\_\_
- No

**Interpreter Service required**

- Yes, language \_\_\_\_\_
- No

**Outpatient Infusion Services Intake Team:**

Please check the appropriate box for the patient's preferred infusion center location:

- PORTLAND Phone-503-215-6046 Fax-503-487-3582
- WILLAMETTE FALLS Phone-503-215-6046 Fax-503-487-3582
- MEDFORD Phone-541-732-7000 Fax-541-732-3939
- HOOD RIVER Phone-541-387-6445 Call for fax #
- SEASIDE Phone-503-717-7650 Fax-503-470-3146
- NEWBERG Phone-503-537-6040 Fax-503-205-8720