| ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER | |
|---|---|
| ***ALLERGIES/REACTIONS (REQUIRED):*** | Yakima Outpatient Infusion Care<br>808 N 39th Ave Yakima WA 98902<br>Phone: 509-575-1174<br>Fax: 509-577-5021 |
| **ORDERS WITH CHECK BOXES** | When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated. |
| **CODE STATUS** | Patients will be considered FULL CODE unless marked otherwise. If the patient has a POLST, advance directive, or living will, please include a copy with the orders. |

# *GOLIMUMAB (SIMPONI ARIA)*

Patient Name:_____ Requested Start Date: _____/_____/_____
Date of Birth:_____/_____/_____ Patient Weight: _____ kg Patient Height: _____

***DIAGNOSIS & ICD-10 CODE*:**
❑ Rheumatoid Arthritis (ICD-10: _____) ❑ Other: _____ (ICD-10: _____)

***REQUIRED*:** H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
***If required documentation not received with this order, scheduling of treatment will be delayed until complete information is available***

***REQUIRED BASELINE LABS & INFORMATION:***
- ✓ CBC & CMP
- ✓ Negative Latent TB Test (Date: _____ | ❑ QuantiFERON Gold | ❑ PPD | ❑ Chest X-Ray | ❑ Other: _____)
- ✓ HBV Screening/Status (Date: _____ | HepBsAg _____ | HepBsAb _____ | HepB Core Ab _____)

***ROUTINE LABS:*** ❑ CBC w/ diff | ❑ CMP | ❑ ESR | ❑ CRP | ❑ Other: _____
***ROUTINE LAB FREQUENCY:*** ❑ Each Infusion | ❑ Other: _____

***ACCESS:*** *Access and maintain IV site or Port-A-Cath in accordance with the appropriate MYM OIC P&Ps*

***TREATMENT REGIMEN:*** *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)*

**Golimumab (Simponi Aria) **PATIENT WEIGHT REQUIRED****

❑ Induction/Initiation:
2 mg/kg x _____ kg = _____ mg/dose (diluted) IV over 30 minutes on week 0 and week 4 then every 8 weeks

❑ Subsequent/Maintenance Infusions:
2 mg/kg x _____ kg = _____ mg/dose (diluted) IV over 30 minutes every 8 weeks

***MONITORING:*** Vitals at baseline and at completion of infusion.
***SUPPORTIVE CARE*:** Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

***DISCHARGE*:** 30 minutes after infusion is complete when vital signs are stable and hypersensitivity symptoms are absent. Waiting period can be waived by patient on subsequent infusions.

Provider Signature: _____ Date: _____
Print name: _____ Phone # _____ Fax # _____

❑ NEW REFERRAL ❑ UPDATED REFERRAL ****Expires 12 months from written date****

**Patient Identification - Attach Patient Label**

Name:

MRN:

Age / Sex and Gender:

GOLIMUMAB (SIMPONI ARIA)

MultiCare

Yakima Memorial Hospital