Endeavor Health SM

Golimumab (Simponi ARIA) Infusion Therapy Orders

Edward-Elmhurst Cancer Centers
120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/646-2273 Fax: 630/548-6617

24600 W. 127th Street; Plainfield, IL 60585
Phone: 630/646-2273 Fax: 630/548-6617

177 E. Brush Hill Road; Elmhurst, IL 60126
Phone: 630/646-2273 Fax: 331/221-3887

Patient Name: _____ DOB: _____

*****Please include current history and physical and any recent labs/tests (if applicable)*****

PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

Pre-Authorization # or Call Reference #: _____
(Ordering Physician Office is Responsible to Obtain Authorization/Referral)

☐ **Check if insurance requires drug to be provided by specialty pharmacy**

Contact Name and Phone Number of Insurance Company: _____

If you have any questions regarding pre-authorizations, please contact (630) 527-3788 and ask for the billing department.

Diagnosis (ICD-10 Required): _____ Weight (lbs/kg): _____

HBV Testing Required Prior to First Dose - **Attach Copy of Results (Date):** _____ Result Neg: ☐ Yes ☐ No

Annual TB Testing Required **Attach Copy of Results (Date):** _____ Result Neg: ☐ Yes ☐ No

Is this their first dose? ☐ Yes ☐ No

Dose: _____ mg/kg = _____ mg

Visit Frequency: _____

Dosing Guidelines (also see package insert):

• **Rheumatoid Arthritis**	Simponi ARIA for IV: 2mg/kg at **weeks 0, 4, and then every 8 weeks**

*****Note: Corticosteriods, *nonbiologics* disease-modifying antirheumatic drugs (DMARDS), and/or NSAIDS may be continued for the treatment of Rheumatoid Arthritis, Psoriatic Arthritis, or Ankylosing Spondylitis. Golimumab should not be used in combination with *biologic* DMARDS. Patients should not get LIVE vaccines. Notify ordering MD to hold treatment for s/s of active infection. Dose will be rounded to nearest vial size.**

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Pre-Medications: (Please mark all that apply)

- ☐ Tylenol 650mg po prior to infusion
- ☐ Benadryl 25mg po prior to infusion
- ☐ Benadryl 25mg IVPB prior to infusion

In the event of a hypersensitivity reaction during the infusion of this medication, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient and your office will receive notification of the event.

In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.

Physician Signature: _____ **Date:** _____

Ordering Physician NPI: _____ **Swedish Hospital NPI:** **1831151257**

Physician Name (Please Print)	**Office Phone**	**Fax Number**

Revision/Review Date: 12/2024