BioPlus® Infusion

Fax your completed order to 877-734-1157

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 IV x (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 4/24/23. 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.