Northern Light Health

☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4589; Fax: 207-768-4183
☐ NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970
☐ NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801
☐ NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788
☐ NL Infusion Care, **Waterville**
Phone: 207-861-3380; Fax: 207-861-3348
☐ NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485
☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418
☐ NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917
☐ NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

OP golimumab (Simponi Aria) (Paper)

Diagnosis:

☐ Psoriatic arthritis
☐ Rheumatoid arthritis
☐ Ankylosing spondylitis
☐ Other _____ **ICD10:** _____

Hepatitis and Tuberculosis Serologies Completed: ***Note:** *If NO, treatment will not be scheduled until results are available.*

Hepatitis B: Yes ☐ No ☐ Date:____/____/____ Result: _____
Hepatitis C: Yes ☐ No ☐ Date:____/____/____ Result: _____
Quantiferon TB Gold Test OR T SPOT: Date:____/____/____ Which test: _____Result: _____

IV Access:

☐ Saline Lock:
☑ Insert peripheral Saline Lock; *may leave in for consecutive treatment days*
☑ Discontinue Saline Lock after therapy completed
☐ PICC Line:
☑ Routine PICC Line Care, labs and restoration
☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)
☐ Porta cath / Central Access Device (Hickman, Triple lumen):
☑ Porta cath access, labs, restoration and de-access / Central Access Device use and care

Height: _____ cm **Weight:** _____ kg

Premedication:

☐ Acetaminophen (Tylenol) *650 mg, PO, ONCE*
☐ Cetirizine (Zyrtec) *10 mg, PO, ONCE*
☐ methylPREDNISolone *40 mg, Soln, IVP, ONCE*
☐ methylPREDNISolone *125 mg, Soln, IVP, ONCE*
☐ methylPREDNISolone _____ *mg, Soln, IVP, ONCE*

Medication:

☑ **golimumab (Simponi Aria)** *2 mg/kg = _____mg/100 mL 0.9% Sodium Chloride, IVPB, Infuse over 30 minutes*

Treatment Schedule:

☐ *One time dose*
Initial therapy: ☐ *Weeks 0 and 4 then* ☐ *Every 8 weeks or* ☐ *Every _____ weeks*
Maintenance: ☐ *Every 8 weeks or* ☐ *Every _____ weeks*
Duration: ☐ *6 months* ☐ *1 year*

Other:

_____

_____

_____

_____

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Date: _____ Time: _____
Provider Signature: _____ Print Name: _____
Phone: _____ Fax: _____
Pharmacy Signature: _____

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS
October 2024