GOLIMUMAB (Simponi) Infusion Order Form

REDINGTON-FAIRVIEW GENERAL HOSPITAL
(207) 474-5121 / WWW.RFGH.NET
Skowhegan, Maine 04976

Diagnosis [ ] Rheumatoid arthritis [ ] Psoriatic arthritis [ ] Other:

Weight: _____kg Height: _____inches [ ] New treatment
[ ] Transfer – Receiving golimumab since_____

Negative TB test date _____

Prior to initial therapy: (Provide copies if results not reported in RFGH EMR)

- Positive for RF or anti-CCP, OR tested for all biomarkers but results are negative (RF, anti-CCP, CRP, ESR)
- TB screen with PPD or IGRA before start of therapy if none in past 12 months.
- Hepatitis C virus antibody, HIV
- Screen for Hepatitis B infection: Hep B surface antigen, Hep B Antibody, Hep B Core Antibody total. .
- Documentation that patient is currently taking methotrexate, has a contraindication to methotrexate or has failed methotrexate therapy.

PRE-MEDICATE (30 minutes before infusion) **or confirm patient has taken prior to arrival**

[ ] acetaminophen 1000 mg PO
[ ] loratadine 10 mg PO
[ ] diphenhydramine 25 mg PO
[ ] Methylprednisolone 40 mg IV
[ ] Hydrocortisone 50 mg IV
[ ] Other:

Golimumab IV 2 mg/kg

[ ] Initial – weeks 0,4,and then every 8 weeks [ ] **Maintenance** – every 8 weeks

Screen patient for symptoms of current infection. Defer treatment and contact prescriber if noted.
Instruct patient to report any symptoms of discomfort or an allergic reaction immediately.
Provide patient with medication guide before administration of each dose. Allow the patient time to read and ask questions. Document process in chart.
Administer diluted in 100 mls sodium chloride 0.9%.
Infuse over 30 minutes through a 0.22 -micron low protein-binding filter.
Vital Signs: prior to infusion, at 15 minutes, & post infusion. May be discharged if post-infusion vital signs are stable. Instruct patient to seek medical attention if they feel sick or develop a fever, cough, or other signs of infection.

[X] **Repeat TB screen** with IGRA, if no IGRA or PPD in the past 12 months
[ ] Other:

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] complete [ ] not needed#
#If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Duration of authorization:_____

Checklist for non-RFGH credentialed providers:

Annually: [ ] H&P completed with last year

If new therapy: [ ] Pretreatment lab results [ ] Problem list, current medication and allergies attached

FAX to RFGH Infusion clinic at 207-858-2404 Contact Infusion Clinic at 207-858-8722

Prep: 9/2025

Provider signature _____Date_____time_____

Printed name_____ Phone # _____

Patient _____

dob_____ phone #_____