LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
For Referrals: (541) 271-2163 – Press #3 (all other services) then press # 2 (Referrals)
For Outpatient Nursing: (541) 271-2171 ext. 5205
FAX: (541) 271-5433

GOLIMUMAB *(SIMPONI ARIA)* ADMINISTRATION

Patient Name _____ **DOB** _____

Patient Phone # _____ **Patient Weight (Kg)** _____ **Patient Height (cm):** _____

Patient Allergies _____

Provider _____ **NPI#** _____

ICD-10 Code (REQUIRED) _____ **J Code** _____

Primary Diagnosis _____

Secondary Diagnosis _____

Duration (or # of treatments): _____ **Anticipated Infusion Date** _____

INSTRUCTIONS TO PROVIDER:

- ***Please ensure insurance authorization has been initiated.***
- *Lab orders should NOT be included on this form – place orders via usual method.* ***Lab monitoring is the responsibility of the ordering Provider.***
- *This plan will expire* ***after 365 days****, at which time new orders will need to be placed.*

MEDICATIONS:

☒ **golimumab** *(SIMPONI ARIA)* in 100 mL **0.9% Sodium Chloride**, IV infusion, **x** 1 over 30 minutes; Administer with in-line 0.22-micron filter

- ☒ Weight _____ (Kg)
- ☒ **Dose:** 2 mg/Kg **x** weight (Kg) = _____ mg (consider rounding to nearest 50 mg)
  - ☐ **Induction Doses:** every 4 weeks **x** 2 doses (week 0 and week 4)
  - ☐ **Maintenance Doses:** every 8 weeks thereafter (week 12 and beyond)

ORDERING GUIDELINES:

☒ Send **FACE SHEET and H&P or most recent chart note**

☒ It may be indicated to continue treatment with corticosteroids, nonbiologic DMARDs, and NSAIDs. Golimumab **SHOULD NOT** be combined with other biologic DMARDs or JAK inhibitors.

- PRIOR to initiation of treatment, obtain baseline CBC and CMP, complete viral hepatitis and TB test (PPD or QuantiFERON Gold) and ensure all immunizations are current.
- Monitor closely for signs and symptoms of TB, hepatitis, infection, malignancy, new-onset or worsening heart failure. Monitor LFTs, creatinine and CBC at regular intervals.

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Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

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PRE-MEDICATIONS *(Administer 30 to 60 minutes prior to each infusion)*:

- ☒ No routine pre-medications necessary. Selected pre-meds may be given if patient has reaction and requires pre-medications for future doses.
- ☒ **acetaminophen** *(TYLENOL)* tablet 650 mg, PO **x** 1 PRN if patient had reaction to previous golimumab infusions
- ☐ **cetirizine** *(ZYRTEC)* tablet 10 mg, PO **x** 1 PRN if patient had reaction to previous golimumab infusions

TREATMENT PARAMETERS:

- ☒ HOLD treatment and contact provider if hepatitis B or TB test results are positive, or if screening has not been performed prior to first dose.
- ☒ HOLD treatment and contact provider if patient has evidence of an active infection, if patient has a temperature **greater than** 100.4˚F, complains of symptoms of acute viral or bacterial illness, or if patient is taking antibiotics for current infection.

NURSING ORDERS:

- ☒ Document weight each visit. Notify Provider if weight change results in change in dose.
  Notify Provider if patient is more than 12 weeks overdue for labs (CBC with diff and CMP).

HYDRATION / MAINTENANCE TKO:

- ☒ **0.9% sodium chloride** infusion, 25 mL/hour, IV **x** 1 PRN per policy - flush/hydration/main bag/TKO

LINE CARE MAINTENANCE:

- ☒ Follow facility policies and procedures for all vascular access maintenance with appropriate flush solutions, de-clotting (**alteplase**), and/or dressing changes.
- ☒ **alteplase** *(CATHFLO ACTIVASE)* injection 2 mg/2 mL, intra-catheter **x** 1 PRN de-clotting per facility policy for 2 doses
- ☒ **heparin, porcine (Preservative Free)** 100 units/mL IV syringe, 500 units, intra-catheter **x** 1 PRN line care
- ☒ **0.9% sodium chloride** flush, 10 to 30 mLs IV; See facility policy and/or medication admin instructions, flush as needed
- ☒ If applicable, may remove PICC line at the completion of course of therapy

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Date _____ Time _____ Provider Signature _____

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EMERGENCY MEDICATIONS FOR HYPERSENSITIVITY / INFUSION REACTION:
** *Itching, hives, fever* **

- ☒ **STOP MEDICATION INFUSION if allergic reaction occurs**
- ☒ Establish IV access and infuse **0.9% sodium chloride** 500 mL at 25 mL/hour PRN Hypersensitivity / Allergic reaction
- ☒ VS Q15 minutes **x** 4 and PRN
- ☒ **acetaminophen** *(TYLENOL)* 650 mg PO Q4HRS PRN Hypersensitivity / Allergic Reaction.
- ☒ **diphenhydramine** *(BENADRYL)* 25 MG IVP PRN Hypersensitivity / Allergic Reaction **x** 1 dose. May repeat **x** 1 ***{Maximum dose = 50 mg}***
- ☒ **NOTIFY** Provider of Hypersensitivity / Allergic Reaction
- ☒ **hydrocortisone** 100 mg IVP PRN Hypersensitivity / Allergic Reactions **x** 1 dose if reaction continues and is not relieved by maximum dose of **diphenhydramine**

ANAPHYLAXIS REACTION
** *Wheezing, Dyspnea, Hypotension, Angioedema, Chest pain, Tongue swelling* **

- ☒ Transfer to Emergency Department (ED) as needed, and **NOTIFY** Provider
- ☒ **epinephrine** 0.3 mg IM PRN anaphylaxis **x** 1 dose

Date _____ Time _____ Provider Signature _____

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