Infusion Center
Kennebunk ▪ Portsmouth ▪ Scarborough ▪ Topsham
Phone: 207-303-3225 Fax:207-692-2473

Simponi IV and SQ(Golimumab) Order Form – J1602

Patient Name:_______________________________________ **DOB:**_______________

Diagnosis: _____________________________________ Diagnosis Code:______________

Height: _____(cm) Actual Weight: ____(kg) Allergies: ______________________________

Please list any premeds needed here.____

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☐ **Psoriatic arthritis, Rheumatoid Arthritis and Ankylosing Spondylitis: IV:** 2 mg/kg at weeks 0, 4, and then every 8 weeks thereafter. ****Vial size is 50mg/4ml please dose accordingly****

Simponi Aria 2mg/kg IV: ☐ **Initial** ☐ **4 weeks** ☐ **q8 weeks**

Doses valid through___/___/____

☐ **Psoriatic arthritis, Rheumatoid Arthritis and Ankylosing Spondylitis: SubQ:** 50mg SQ once a month.

Simponi SQ 50mg: ☐ **q28 days**

☐ **Ulcerative colitis: SubQ:** Induction: 200 mg at week 0, then 100 mg at week 2, followed by maintenance therapy of 100 mg every 4 weeks.

Simponi SQ: ☐ **Initial 200mg** ☐ **2week 100mg** ☐ **100mg q4 weeks.**

Orders valid through___/___/_____

Required labs: TB screening prior to treatment then yearly, HBV screening prior to therapy and CBC with differential prior to therapy then every 3 to 6 months.

- **In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: ____

Provider Signature: ____________________________________ Date: ___________

Phone: _____________ Fax: _____________ Pager: _____________