



Patient Name
DOB
MRN
Physician
FIN

Defaults for orders not otherwise specified below:

- Interval: Induction (Ulcerative Colitis) week 0, week 2, then Every 28 days
- Interval: Every 28 days

Duration:

- Until date: _____
- 1 year
- _____ # of Treatments

Anticipated Infusion Date _____ ICD 10 Code with Description _____

Height _____ (cm) Weight _____ (kg) Allergies _____

Provider Specialty

- | | | | |
|---|---|---|---------------------------------------|
| <input type="checkbox"/> Allergy/Immunology | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> OB/GYN | <input type="checkbox"/> Rheumatology |
| <input type="checkbox"/> Cardiology | <input type="checkbox"/> Internal Med/Family Practice | <input type="checkbox"/> Other | <input type="checkbox"/> Surgery |
| <input type="checkbox"/> Gastroenterology | <input type="checkbox"/> Nephrology | <input type="checkbox"/> Otolaryngology | <input type="checkbox"/> Urology |
| <input type="checkbox"/> Genetics | <input type="checkbox"/> Neurology | <input type="checkbox"/> Pulmonary | <input type="checkbox"/> Wound Care |

Site of Service

- | | | | |
|--|--|---------------------------------------|---|
| <input type="checkbox"/> SH Gerber | <input type="checkbox"/> SH Lemmen Holton (GR) | <input type="checkbox"/> SH Pennock | <input type="checkbox"/> SH United Memorial |
| <input type="checkbox"/> SH Helen DeVos (GR) | <input type="checkbox"/> SH Ludington | <input type="checkbox"/> SH Reed City | <input type="checkbox"/> SH Zeeland |

Appointment Requests

- Infusion Appointment Request

Status: Future, Expected: S, Expires: S+366, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Injection and possible labs

Safety Parameters and Special Instructions

- ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 4

GOLIMUMAB (SIMPONI):

An FDA-approved patient medication guide, which is available with the product information and as follows, should be dispensed with this medication

https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/125289s135lbl.pdf

Tuberculosis surveillance and management: Screen and treat latent infection prior to starting therapy.

Hepatitis B surveillance and management: Screen prior to initiating therapy. Refer to specialist as warranted by serology.

TB skin test, hepatitis B surface antigen (HBsAg) test, liver function test (LFT), complete blood count (CBC), up-to-date vaccinations, risk assessment for cancer, and pregnancy testing. Monitor for signs of tuberculosis throughout therapy. Do not initiate therapy if active infection is present. Monitor closely for signs and symptoms of infection. Monitor for signs/symptoms of malignancy (eg, splenomegaly, hepatomegaly, abdominal pain, persistent fever, night sweats, weight loss). Identify history of latex or polysorbate 80 allergy; some dosage containers may contain these agents. Monitor LFTs, CBC at regular intervals. Assess results of laboratory tests (PDD) at regular intervals during treatment.

If self-injected, teach patient appropriate injection technique and syringe/needle disposal.

- ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 4

HEPATITIS B VIRUS SURVEILLANCE AND MAINTENANCE RECOMMENDATIONS: Screen prior to treatment. Refer to specialist as warranted by serology.

- ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 5

TUBERCULOSIS SURVEILLANCE AND MANAGEMENT RECOMMENDATIONS: Screen prior to treatment. Treat latent infection prior to starting therapy.

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NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.



Patient Name _____
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Labs

	Interval	Duration
<input checked="" type="checkbox"/> Complete Blood Count w/Differential Status: Future, Expected: S, Expires: S+184, URGENT, Clinic Collect, Blood, Blood, Venous		
<input checked="" type="checkbox"/> Hepatic Function Panel (Liver Panel) Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous		
<input checked="" type="checkbox"/> Hepatitis B Surface Antigen Level Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous		
<input checked="" type="checkbox"/> Hepatitis B Core Total Antibody Level Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous		
<input type="checkbox"/> Other Labs: _____ <input type="checkbox"/> Every ___ days <input type="checkbox"/> Until date: _____ <input type="checkbox"/> Once <input type="checkbox"/> 1 year <input type="checkbox"/> _____ # of Treatments		
<input checked="" type="checkbox"/> Arrange For Patient To Have Id Tb Skin Test Administered And Read Or Serum Tb Screening Lab Prior To Therapy Or Annually		
<input type="checkbox"/> ONC PROVIDER REMINDER 28 Arrange for patient to have intradermal TB skin test (tuberculin PPD) screening performed and read prior to initiating therapy and annually.	Once	1 treatment
<input type="checkbox"/> TB Screen (Quantiferon Gold) Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous	Once	1 treatment

Nursing Orders

<input checked="" type="checkbox"/> ONC NURSING COMMUNICATION 200 May Initiate IV Catheter Patency Adult Protocol.



Treatment Parameters

<input checked="" type="checkbox"/> ONC MONITORING AND HOLD PARAMETERS 3 May proceed with treatment if hepatitis B core antibody and surface antigen labs have been resulted prior to the first dose, and the results are negative.
<input checked="" type="checkbox"/> ONC MONITORING AND HOLD PARAMETERS 4 May proceed with treatment if tuberculosis screening test with either TB Screen blood test (QuantIFERON® Gold Plus) or TB skin test have been resulted prior to first dose and the results are negative.

Medications

<input checked="" type="checkbox"/> Golimumab (simponi) Autoinjector Or Prefilled Syringe Rotate injection sites and avoid injecting into tender, red, scaly, hard, or bruised skin, or areas with scars or stretch marks. If multiple injections are required for a single dose, administer at different sites on body. Hold autoinjector firmly against skin and inject subcutaneously into thigh, lower abdomen, or upper arm. A loud click is heard when injection has begun. Continue to hold autoinjector against skin until second click is heard (may take 3 to 15 seconds). Ankylosing spondylitis, Psoriatic arthritis, or Rheumatoid arthritis: <input type="checkbox"/> 50 mg Induction for Ulcerative Colitis: <input type="checkbox"/> 200 mg, Subcutaneous at week 0 <input type="checkbox"/> 100 mg, Subcutaneous at week 2 Maintenance for Ulcerative Colitis: <input type="checkbox"/> 100 mg, Subcutaneous

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.



TRANSCRIBED: TIME	DATE	VALIDATED: TIME	DATE	ORDERED: TIME	DATE	Pager #
		Sign		R.N. Sign		Physician Print
						Physician

EPIC VERSION DATE: 09/12/20

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.