Patient Name:______________________________________

DOB:_____________________ Wt(kg):_________________

Allergies:___________________ Phone:_________________

Simponi Aria (Golimumab) Infusion Orders

Required Information:

- Signed order from prescribing provider
- Patient demographics including insurance information
- Supporting clinical documentation: Visit notes, diagnostic results
- Required Labs: TB & Hep B screening

Primary Diagnosis:

- Ankylosing Spondylitis ICD-10 :________)
- Rheumatoid Arthritis(ICD-10:__________)
- Rheumatoid Juvenile Idiopathic Arthritis (ICD-10 :_______)
- Psoriatic Arthritis (ICD-10 :_______)
- Other (ICD-10 :__________)

SIMPONI ARIA ORDERS

Dose: Simponi Aria 2mg/kg

Simponi Aria _____mg

Frequency: Induction: weeks 0, 4, then every 8 weeks

Subsequent: every _____ weeks

Date of Last Simponi Aria: ______________

Administered per manufacturer guidelines

PRE-MEDICATIONS

PO Tylenol _____mg

PO Cetirizine _____mg

IV Solu-medrol _____mg

PO Loratadine _____mg

PO IV Diphenhydramine _____mg

PO IV Other:______________ _____mg

LABS

CBC

CMP

CRP

ESR

TB Quantiferon Gold

Hep B Core/Surface AG

Uric Acid

Other:______

Other:______

Frequency:

- Every Visit
- Every Other Visit
- One time only
- Other:____________

CPL Acct #:__________

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

____

____

____

Physician Name:	Phone:	Fax:
Physician Signature:	NPI:	Date: