SIMPONI ARIA (GOLIMUMAB)
INFUSION ORDERS

REQUIRED INFORMATION

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ Clinical/Progress Notes, Labs, Tests supporting primary diagnosis
- ☐ TB test results (yearly testing)
- ☐ Hepatitis B Protocol: Hep B surface antigen & Hep B Core AB total required

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:
- ☐ Rheumatoid Arthritis (ICD-10___________)
- ☐ Psoriatic Arthritis (ICD-10___________)
- ☐ Ankylosing Spondylitis (ICD-10___________)
- ☐ Other:______________________ (ICD-10___________)

J Code: J1602

Patient Weight: _________kg

Simponi Aria Orders

Initial Dose: ☐ 2mg/kg infused over 30 mins at weeks 0, 4 and then every 8

Maintenance Dose: ☐ Every 8 weeks

Date of last: ☐ Remicade ☐ Orencia ☐ Humira ☐ Cimzia ☐ Enbrel

Date of Last Simponi Aria ________________ OR ________________New start

Additional instructions:

Physician Name:	Phone:	Fax:

Physician Signature:	Date: