Simponi ARIA® (golimumab) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
3. TB screening and Hepatitis B screening or testing documentation.

____ ______________________
Patient Name **DOB**

_______ _________________________________ ___________________________
Weight **Allergies** **Patient Phone**

Diagnosis (must include ICD10 code)
☐ Rheumatoid Arthritis**:** __________ ☐ Psoriatic Arthritis: ___________
☐ Ankylosing Spondylitis**:** ___________ ☐ Other: ______________________________

<u>Prescription Orders: Simponi ARIA® (golimumab)</u>
0.2 micron filter must be used during infusion
☐ Initial: 2mg/kg IV. Infuse over 30 minutes at day 0, 4 weeks, and then every 8 weeks
☐ Renewal: Infuse 2mg/kg IV over 30 minutes every 8 weeks.

<u>Pre-medications:</u> ☐ Acetaminophen 650 mg PO ☐ Benadryl 25 mg IVP
☐ Zofran 4 mg IVP ☐ Solu-Medrol 40 mg IVP ☐ Benadryl 50 mg P
☐ Other Premeds Needed ____

<u>Lab orders</u>: ☐ CMP ☐ CBC ☐ ESR ☐ CRP ☐Other: ________________________

Refills: ☐ 12 months or ☐________infusions

____
Physician Name **Phone** **Fax**

____
Physician's signature **Date**

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com

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