

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg
Primary Language: _____ Allergies: _____
Patient Preferred Location: _____

<ICD 10 CODE REQUIRED>

DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

- M05. _____ Rheumatoid Arthritis, w/ Rheumatoid Factor
- M06. _____ Rheumatoid Arthritis, w/o Rheumatoid Factor
- L40.5 _____ Psoriatic Arthropathy
- M45. _____ Ankylosing Spondylitis
- Other: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.
LAB RESULTS: Include Negative Hepatitis B within 3 years & Negative TB within 12 months. If the patient is unable to take methotrexate, then provider must include supporting documentation as to reason/rational.

PRESCRIPTION

Pre-Medications

- Acetaminophen: 650 mg PO
- Cetirizine: 10 mg PO
- Diphenhydramine: 25 mg PO
- Diphenhydramine: 25 mg IVP
- Famotidine: 20 mg PO
- Methylprednisolone: 125 mg SIVP
- Other: _____

Lab Orders+

Required: Negative TB, annually
+Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider.

Simponi Aria (golimumab)

Loading Dose:

- IV:** Infuse 2 mg/kg in 100 mL of 0.9% Sodium Chloride over at least 30 minutes via pump using 0.2-micron filter at weeks 0 and 4

Maintenance:

- IV:** Infuse 2 mg/kg in 100 mL of 0.9% Sodium Chloride over at least 30 minutes via pump using 0.2-micron filter every 8 weeks for one year

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first infusion.

Comments: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ **Signature:** _____
Date: _____ NPI #: _____ Specialty: _____
Supervising Physician: _____ (If Applicable)
Address: _____ City: _____ State: _____ Zip: _____
Contact Name: _____ Phone: _____ Fax: _____ Email: _____