Simponi Aria Order Form
(golimumab)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: ☐ M ☐ F Ht: _____ Wt: _____ ☐ lbs ☐ kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

<ICD 10 CODE REQUIRED>

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, and 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 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 every 8 weeks for one year

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

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

Comments:

_____

_____

PRESCRIBER INFORMATION

Prescriber Name: _____ Signature: _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____