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

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: _____

Medication Order

Pre-Medications

☐ Acetaminophen: 650 mg PO
☐ Cetirizine: 10 mg PO
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IVP
☐ Famotidine: 20 mg PO
☐ Methylprednisolone: _____mg
Other: _____

Lab Orders

Requested Add'l Lab Orders:
_____
_____

Lab Frequency: _____every _____weeks

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

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

Comments: _____

Required Clinical Documentation

REQUIRED: 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/rationale.

Is the patient on any other disease modifying therapy? ☐ Yes ☐ No
If yes, please note therapy and last dose:
_____

Medix Infusion will collect all necessary labs if not included in referral documents

Referring Provider Information

To Prescriber: By signing this form and utilizing our services, you are also authorizing Medix Infusion to serve as your prior authorization designated agent in deaing with medical and prescription insurance companies, and co-pay assistance foundations.

Signature: _____Date: _____

Prescriber Name: _____NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

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

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