

(golimumab)

Date: _____

SIMPONI ARIA infusion orders

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ Discontinuation Order

PHYSICIAN INFORMATION

Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: Fax:
Practice Address:	City: State: Zip Code:

DIAGNOSIS Please provide ICD-10 code

- ☐ _____ Rheumatoid Arthritis
☐ _____ Active Psoriatic Arthritis (PSA)
☐ _____ Active Ankylosing Spondylitis (AS)

☐ _____ (other)

PRE-MEDICATION

- | | |
|--|---|
| ☐ Tylenol 1000mg PO | ☐ Solu-Medrol 125mg IVP |
| ☐ Diphenhydramine 25mg PO | ☐ Solu-Cortef 100mg IVP |
| ☐ Cetirizine 10mg PO | ☐ Diphenhydramine 25mg IVP |
- _____ (other) _____ (other)

SIMPONI ARIA ORDERS

PATIENT WEIGHT

_____ lbs.
_____ kg

DOSAGE:

- ☐ 2mg/kg (weight based)
☐ _____mg/kg (flat dose)
☐ Other _____

Frequency:

- ☐ every 0,4, and every 8 weeks (induction)
☐ every _____ weeks
☐ Other _____
_____ Total Dosages/ ☐ Refills

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____