

SIMPONI ARIA

(golimumab)



PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results
- Hep B Panel

PRIMARY DIAGNOSIS

- L40.50 Arthropathic psoriasis, unspecified
- L40.52 Psoriatic arthritis mutilans
- M05.79 Rheumatoid arthritis with rheumatoid factor multiple sites without organ/system involvement
- M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified
- M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
- M06.89 Other specified rheumatoid arthritis, multiple sites
- M06.9 Rheumatoid arthritis, unspecified
- M45.0 Ankylosing spondylitis of multiple sites in spine
- Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

- Per infusion clinic protocol: No recommended standard pre-meds for Simponi ARIA
- Provider Prescribed: _____

PRIMARY MEDICATION ORDER

- Simponi ARIA 2mg/kg (_____mg) IV at Week 0, 4, and every 8 weeks thereafter
- Simponi ARIA _____mg/kg (_____mg) IV every _____ weeks thereafter
- Other: _____

First Dose: Y N Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- Start PIV/ACCESS CVC Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
- Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature _____

Date _____