

# SIMPONI ARIA

(golimumab)

FAX to +1 208.963.3245 or  
Email to [intake@infusionspecialists.org](mailto:intake@infusionspecialists.org)  
To ensure processing of your order, please  
complete all fields.



## 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
- Negative TB Results
- Tried/Failed Therapies

## 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: \_\_\_\_\_

## 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 Infusion Specialists' protocol (See [infusionspecialists.org](http://infusionspecialists.org) for detailed policy)
- Other Flush Orders: Please fax other line care orders if checking this box

## ADVERSE REACTION & ANAPHYLAXIS ORDERS

- Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol (See [infusionspecialists.org](http://infusionspecialists.org) 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