

Simponi Aria (golimumab) ORDER FORM

Prerequisites to treatment – ensure the following information is complete and attached with

referral: Demographics Prior Authorization Office/Progress Notes

PATIENT INFORMATION

Patient Name: _____ D.O.B. _____ Male Female

Phone Number: _____ Allergies: _____

DIAGNOSIS

- | | |
|---|---------------|
| <input type="checkbox"/> Rheumatoid Arthritis | ICD 10: _____ |
| <input type="checkbox"/> Psoriatic Arthritis | ICD 10: _____ |
| <input type="checkbox"/> Ankylosing Spondylitis | ICD 10: _____ |
| <input type="checkbox"/> Other: _____ | ICD 10: _____ |

PRE-MEDICATION

- | | |
|--|--|
| <input type="checkbox"/> Tylenol 1000mg PO | <input type="checkbox"/> Solu-Medrol 40mg IVP |
| <input type="checkbox"/> Cetirizine 10mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Other: _____ |

MEDICATION

Simponi Aria

Dosing: IV _____mg

Duration: IV Infusion over 30 minutes OR IV Infusion over _____ minutes

Frequency: Every 8 weeks OR Other: _____

Route: Peripheral IV per protocol PICC capping per protocol PORT capping per protocol

New Start (0,4, and every 8 weeks) OR Continuation of therapy

Date of last dose (if applicable) _____

Monitor vitals baseline and post infusion

Other: _____

REFERRING PROVIDER INFORMATION

For questions regarding patient's care during the infusion, please contact:

Facility: _____ Fax: _____

Name 1st Point of Contact (must be available during infusion): _____

Phone: _____

Name 2nd Point of Contact (must be available during infusion): _____

Phone: _____

By referring to the Medical Associates Infusion Clinic, it is recognized and agreed upon that the referring specialist or delegate listed above will be available and responsive during the duration of the scheduled infusion appointment. This contact should be available to answer any questions and/or address concerns related to the care of the patient. The on-site provider within the Infusion Clinic will be responsible for urgent patient care needs during the infusion.

Ordering Provider Name (please print): _____

Ordering Provider Signature: _____ Date: _____

FAX NUMBER: 563-584-4232

PHONE NUMBER: 563-584-4370

Order valid for 1 year from date of signature unless otherwise specified.