Simponi Aria
(golimumab)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

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

PRESCRIPTION

Simponi ARIA Initial Dosing: ☐ 2 mg/kg IV at weeks 0, 4, and then every 8 weeks x 1 year

Maintenance Dose: ☐ 2 mg/kg IV every 8 weeks x 1 year

☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

REQUIRED DOCUMENTATION

- Insurance Card
- Patient Demographics
- Most recent labs
- Negative TB Results
- H&P
- Medication List
- Tried/failed therapies
- Hep B Panel

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol
(See aiscaregroup.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

Per infusion center protocol: No recommended standard pre-meds for Simponi ARIA.

☐ Provider Prescribed: _____

LINE CARE ORDERS

Start PIV/Access CVC

Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*

☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

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

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.