

Simponi ARIA® (golimumab) Order Form

Please include the following (required):

1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
3. TB screening and Hepatitis B screening or testing documentation.

Patient Name

DOB

Weight

Allergies

Patient Phone

Diagnosis (must include ICD10 code)

- Rheumatoid Arthritis: _____ Psoriatic Arthritis: _____
 Ankylosing Spondylitis: _____ Other: _____

Prescription Orders: Simponi ARIA® (golimumab)

****0.2-micron filter must be used during infusion****

- Initial: 2mg/kg IV. Infuse over 30 minutes at day 0, 4 weeks, and then every 8 weeks
 Renewal: Infuse 2mg/kg IV over 30 minutes every 8 weeks.

Pre-medications:

- Acetaminophen 650 mg PO Benadryl 25 mg IVP
 Zofran 4 mg IVP Solu-Medrol 40 mg IVP Benadryl 50 mg IVP
 Other Premeds Needed _____

Lab orders: CMP CBC ESR CRP Other: _____

Refills: 12 months or for _____ infusions

Provider Name

Phone

Fax

Provider's signature

Date

**Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.
For any other questions please call (469) 480-9649.
Or visit us online at www.ntinfusioncenters.com**