Ph: (888) 209-8874 Fax: (833) 329-4738

Golimumab (Simponi Aria)

Provider Order Form rev. 12/01/2021

PATIENT INFORMATION

Patient Name: DOB:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

ICD-10 CODE

☐ M06.9 Rheumatoid Arthritis (RA)

☐ L40.52 Active Psoriatic Arthritis (PsA)

☐ M45.9 Ankylosing Spondylitis (AS)

☐ M08.00 Active polyarticular Juvenile Idiopathic Arthritis (pJIA)

☐ Other: ______________________________

MEDICATION ORDER

☑ **Golimumab** (Simponi Aria) in 100ml 0.9% sodium chloride, intravenous infusion over 30 minutes (use in line filter 0.22 micron or less)

- Dose: ☐ 2mg/kg = ________mg / ☐ other ________mg/kg
- Frequency: ☐ induction: week 0, and 4, and then every 8 weeks / ☐ maintenance: every 8 weeks / ☐ other: ____________________________________
- Duration: Infuse over 30 minutes

☑ Flush with 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 30-minute observation period

☐ Patient is NOT required to stay for observation time

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ ______________________ (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Provider Name (Print) **Provider Signature** **Date**

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ ANA (SLE) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months