InfuseAble Care
INFUSION SUITES & IMMEDIATE CARE SERVICES

Patient Name
DOB
Address
Cell Phone

SIMPONI ARIA (golimumab)

Status	☐ New Therapy ☐ Order Renewal ☐ Dosage or Frequency Change
Diagnosis	☐ ICD 10: M06.__ Rheumatoid Arthritis (RA) ☐ ICD 10: M45.__ Ankylosing Spondylitis (AS) ☐ ICD 10: L40.5 Psoriatic Arthritis (PsA) ☐ ICD 10: K51.__ Ulcerative Colitis (UC) ☐ ICD 10 Code: _____ Other: _____
Pertinent Medical Hx	Patient's weight (most recent): _____ lbs / kg (circle one) Date: _____ TB Status & Date: _____ Hepatitis B Status & Date: _____
Labs	Labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician If Infusion Clinic: _____
Premeds	☐ No premeds necessary ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO ☐ cetirizine (Zyrtec) 10mg PO - ***OR*** - ☐ diphenhydramine (Benadryl) 25mg PO ☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV ☐ other: _____
IV Fluids	☐ NS TKO ☐ Other: _____
Medication Order	☐ Initial / Reload: Simponi Aria 2mg/kg IV at Week 0, and 4, then every 8 weeks thereafter. ☐ Maintenance: Simponi Aria 2mg/kg IV every 8 weeks Refills: ☐ x 1 year ☐ x _____doses ☐ No refills; give this dose only.
Monitoring	Monitor for signs/symptoms of hypersensitivity during infusion and 15 mins post-infusion. For any signs of infusion reaction: STOP infusion. Contact on-site provider for instruction.
Additional Orders	
Physician Information	Physician Name _____ NPI _____ Office Contact _____ Phone _____ **Provider Signature:** _____ Date _____

REQUIRED DOCUMENTATION

o	Patient Demographics & **Insurance** Information:	- Copy of patient's insurance card – front and back
o	**Clinical / Progress Notes**, supporting primary diagnosis:	- 2 most recent office notes - Medication history
o	Most Recent **Labs**:	- CMP and CBC - TB screening (PPD, QFT Gold or TSpot) - Baseline Liver Enzymes

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