aleracare
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# Simponi Aria (golimumab)

Provider Order Form rev. 5/5/2023

## Patient Information

Patient Name: DOB:

Patient Phone: Patient Email:

NKDA Allergies: Weight lbs/kg: Height:

Patient Status: New to Therapy Continuing Therapy Therapy Change Last infusion date (if applicable): ___________________

Is the patient pregnant, planning a pregnancy or nursing: Yes No Does the patient need interpreter services: Yes No

## Provider Information

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

## ICD-10 CODE

K50.90 Crohn's/Pediatric Crohn's Disease M06.9 Rheumatoid arthritis M45.9 Ankylosing Spondylitis L40.50 Psoriatic Arthritis

M08.09 Polyarticular juvenile idiopathic arthritis Other: ____________________________________________

## Medication Order

**Simponi Aria** (golimumab) **Dose:** 2mg/kg IV

Other: ___________________________

**Frequency:** At week 0, 4 and every 8 weeks thereafter

Every 8 weeks

Other: ___________________________

## Documentation Required (Note: Send all labs, must include specific labs listed here)

Labs (Hep B, TB, CBC and Liver Function tests)

Insurance Card (front and back) Current Medications History/Progress Notes

## Pre-Medication Order

**acetaminophen** (Tylenol) 500mg 650mg 1000mg PO

**diphenhydramine** (Benadryl) 25mg 50mg / PO IV

**cetirizine** (Zyrtec) 10mg PO

**methylprednisolone** (Solu-Medrol) 40mg IV 125mg IV

**loratadine** (Claritin) 10mg PO

**hydrocortisone** (Solu-Cortef) 100mg IV

Other: ____________________________________________

Dose:__________________ Route:__________________ Frequency: __________________

## Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

**Provider Name** **Provider Signature** **Date**

Order Expiration Date (mm/dd/yy): __________________ (If not indicated order will expire one year from date signature) Check here if this is a stat order