immersiv HEALTH

SIMPONI ARIA® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

***PLEASE COMPLETE ICD-10 FOR SPECIFIC DIAGNOSIS**

- ☐ L40.5___ Psoriatic Arthropathy
- ☐ M05. ___ Rheumatoid arthritis w/ rheumatoid factor
- ☐ M06. ___ Rheumatoid arthritis w/o rheumatoid factor
- ☐ M45. ___ Ankylosing spondylitis
- ☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

- ☐ Insurance Information
- ☐ List of Medications
- ☐ Tried & Failed Therapies
- ☐ Most Recent History & Physical
- ☐ Negative TB & HEP-B screenings

MEDICATION ORDER

- ☐ **LOADING:** Simponi ARIA® (golimumab) 2mg/kg IV in 100ml NS over 30 minutes at week 0 and week 4
- ☐ **MAINTENANCE:** Simponi ARIA® (golimumab) 2mg/kg IV in 100ml NS over 30 minutes every 8 weeks

  *Maintenance dosing scheduled 8 weeks from week 4 dose
- ☐ **OTHER:** _____
- ☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following each administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRE-MEDICATIONS

PO

- ☐ Acetaminophen: 650 mg
- ☐ Cetirizine: 10 mg
- ☐ Diphenhydramine: 25 mg

IV

- ☐ Methylprednisolone: 125 mg
- ☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ _____ **DATE:** _____
(NO STAMPS)

SUBSTITUTION PERMITTED | DISPENSE AS WRITTEN