

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: _____

PRE-MEDICATIONS
PO

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

IV

- Methylprednisolone: 125 mg
 Diphenhydramine: 25 mg

 OTHER: _____ PO IV

 REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

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

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