vitalcare® INFUSION SERVICES of SIOUX FALLS

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SIMPONI ARIA (GOLIMUMAB)
INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis
- ☐ TB Test Results (Yearly Screening)
- ☐ **Hepatitis B Protocol:** Hep B surface antigen and Hep B Core AB total required.

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis: ☐ Rheumatoid Arthritis (ICD-10_____)
☐ Psoriatic Arthritis (ICD-10_____)
☐ Ankylosing Spondylitis (ICD-10_____)
☐ Other:_____ (ICD-10_____)

J Code: J1602

SIMPONI ARIA ORDERS

Initial dose: ☐ 2mg/kg infused over 30 mins at weeks 0, 4 and then every 8 Patient Weight: _____kg

Maintenance dose: ☐ Every 8 weeks

*Date of last ☐ Remicade ☐ Orencia ☐ Humira ☐ Cimzia ☐ Enbrel
☐ Actemra ☐ Kineret ☐ Simponi ARIA dose:_____ Date:_____

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	