SIMPONI ARIA
(golimumab)

FLEXCARE INFUSION CENTERS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Tried/Failed Therapies
- Negative TB Results
- Hep B Panel

PRIMARY DIAGNOSIS

☐ L40.50 Arthropathic psoriasis, unspecified
☐ L40.52 Psoriatic arthritis mutilans
☐ M05.79 Rheumatoid arthritis with rheumatoid factor multiple sites without organ/system involvement
☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified
☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
☐ M06.89 Other specified rheumatoid arthritis, multiple sites
☐ M06.9 Rheumatoid arthritis, unspecified
☐ M45.0 Ankylosing spondylitis of multiple sites in spine
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Simponi ARIA
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Simponi ARIA 2mg/kg (_____mg) IV at Week 0, 4, and every 8 weeks thereafter
☐ Simponi ARIA _____mg/kg (_____mg) IV every _____ weeks thereafter

☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per FlexCare Infusion Centers' protocol (See flexcareinfusion.com for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date

FAX: (888) 219-8102 | EMAIL: orders@flexcareinfusion.com | VISIT: flexcareinfusion.com/referrals