NORTH TEXAS INFUSION CENTERS

Simponi ARIA® (golimumab) Order Form

Please include the following (required):
1. Patient Demographics & Insurance Information
2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
3. TB screening and Hepatitis B screening or testing documentation.

_____ _____
Patient Name **DOB**

_____ _____ _____
Weight **Allergies** **Patient Phone**

Diagnosis (must include ICD10 code)
☐ Rheumatoid Arthritis **ICD10 code:**_____
☐ **Other:** _____
☐

Prescription Orders: Simponi ARIA® (golimumab)

☐ Initial: 2mg/kg (IV). Infuse over 30 minutes. Infuse day 0, 4 weeks, then every 8 weeks
☐ Renewal: Infuse 2mg/kg IV over 30 minutes every 8 weeks.

Pre-medications: ☐ Acetaminophen 650 mg PO ☐ Benadryl 25 mg IVP
☐ Zofran 4 mg IVP ☐ Solu-Medrol 40 mg IVP ☐ Benadryl 50 mg P
☐ Other Premeds Needed _____

Lab orders: ☐ CMP ☐ CBC ☐ ESR ☐ CRP ☐ Other:_____

Refills: ☐ **12 months** ☐ _____ **infusions**

_____
Physician Name **Phone** **Fax**

_____
Physician's signature **Date**

Fax completed form to (214) 887-0436.Contact us directly at: (214) 276-5642.
Or visit us online at www.ntinfusioncenters.com

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