

**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:	