Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226

INFUSION SOLUTIONS

Prince George
2025B Waterside Rd
Prince George, VA 23875

Physician Order - Simponi Aria (golimumab)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS
☐ New Referral ☐ Dose/Frequency Change ☐ Order Renewal

Location Preference (optional)
☐ Richmond ☐ Prince George

* * If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access * *

DIAGNOSIS AND ICD 1-0 CODE	
☐ Rheumatoid Arthritis	M06.9
☐ Ankylosing Spondylitis	M45.9
☐ Arthropathic Psoriasis	L40.50
☐ Juvenile Rheumatoid Arthritis	M08.00
☐ Other: _____	ICD10 _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider	☐ Clinical/Progess Notes
☐ Patient Demographics AND Insurance Information	☐ Labs and Tests Supporting Primary Dx
☐ Hepatitis B Test Results: HBsAg	
☐ QuantiFERON Gold TB Test Results	
☐ Patient currently receiving same therapy at _____ Last dose: _____	
List Tried & Failed Therapies, including duration of treatment	
1)	
2)	
3)	

MEDICATION ORDERS**	
Initial Dosing	☐ Simponi Aria 2mg/kg infuse IV over 30 minutes at week 0, 4, then every 8 weeks
Maintenance Dosing	☐ Simponi Aria 2mg/kg infuse IV over 30 minutes every 8 weeks
Patient Weight = _____ kg	Patient Height = ____ ft ____ in
Duration: ☐ x 6 months ☐ x 1 year ☐ doses _____	

**Patient weight is required for all weight based therapies - please indicate weight in kilograms.

PREMEDICATIONS
☐ Acetaminophen 650mg PO prior to Simpano Aria infusion
☐ Diphenhydramine 25mg PO prior to Simpano Aria infusion
☐ Methylprednisolone 40mg slow IVP
☐ Other:

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing.

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	Contact:
Phone:	Fax:	Email:
Prescriber Signature:		Date:

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
Fax completed form and ALL documentation to 804-554-5848
All information contained in this form is strictly confidential and will become part of the patient's record.