Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

Simponi ARIA (golimumab) IV Infusion ORDER

Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

Diagnosis:_____

DX CODES: *ICD-10* : _____, _____, _____

TB verification *(circle one):* TB skin test TB spot blood test Chest X-RAY □ COPY ATTACHED

Result Date: _____/_____/_____ Result ***(circle one):*** **Positive Negative**

LABS to be drawn: □ **CBC** □ **CMP** □ Other: _____
Lab Frequency**:** _____

Pre- Medications:	**Diphenhydramine PO or IV**	25mg or 50mg	□Yes □ No
	Cetirizine PO	10mg	□Yes □ No
	Acetaminophen PO	650mg	□Yes □ No
	Solu-Medrol IV	_____mg	□Yes □ No

Start Date of Infusion: _____/_____/_____ **Infusion #** _____ □ **Continuation of treatment**

Simponi ARIA (golimumab) IV Dosage:

□ 2mg/kg □ Other: _____

Frequency: □ Induction Dose – 0, 4wks then q 8 wks

□ q 8 wks □ Other: _____

Rx Expiration Date: _____/_____/_____

Printed Provider's Name: _____

Provider Signature: _____

Office Phone Number: _____**Office Fax Number:** _____