Simponi Aria

(Golimumab) Infusion Order

NobleInfusion
Phone: 386-957-9600
Fax: 386-957-9400

PATIENT INFORMATION:

Patient Name: _____ ☐ Male ☐ Female
DOB: _____ Phone number: _____
Reason for treatment: ☐ oral iron intolerance ☐ lack of response to oral iron ☐ Other
Allergies: ☐ NKDA ☐ allergic to _____

DIAGNOSIS:

☐ Rheumatoid Arthritis IDC-10 Code: _____
☐ Psoriatic Arthritis IDC-10 Code: _____
☐ Ankylosing Spondylitis IDC-10 Code: _____
☐ Other: _____ code: _____

PREMEDICATION:

☐ acetaminophen 100 mg PO ☐ Diphenhydramine 25 mg PO ☐ Ceterizine 10 mg PO
☐ Solu Medrol 125 mg IVP ☐ Solu-Cortef 100 mg IVP ☐ Diphenhydramine 25 mg IVP
☐ other _____

REQUIRED TESTING/LABS

☐ Clinical/progress notes, labs, tests supporting primary diagnosis attached
☐ recent labs, Hep B screening (Hep B antigen and core body- not IGM), TB screening within 12 months

SIIMPONI ARI DOSING: (Default Noble Infusion Safety Protocol)

☐ 2mg/kg IV at weeks 0, 4, and then every 8 weeks x 1 year (initial dosing)
☐ 2mg/kg IV every 8 weeks x 1 year
☐ other _____

FREQUENCY:

☐ Every_____ days for _____ doses

ORDERING PROVIDER:

Name: _____ NPI _____
Phone: _____ fax: _____
Practice Address: _____
City: _____ State: _____ Zip: _____

Provider Signature_____ Date: _____

Include with order: most recent visit note, labs, pt face sheet, insurance cards, and other history pertaining to referring medication.