



MEDICATION ORDERS

SIMPONI ARIA (GOLIMUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS		
<input type="checkbox"/> New Referral	<input type="checkbox"/> Dose or Frequency Change	<input type="checkbox"/> Order Renewal

INFUSION OFFICE PREFERENCE (Optional)	
Preferred Location:	<input type="checkbox"/> Montgomery <input type="checkbox"/> Prattville

DIAGNOSIS AND ICD 10 CODE	
<input type="checkbox"/> Moderate to Severe Rheumatoid Arthritis (RA)	ICD 10 Code: M06.9
<input type="checkbox"/> Active Psoriatic Arthritis	ICD 10 Code: L40.52
<input type="checkbox"/> Active Ankylosing Spondylitis	ICD 10 Code: M45.9
<input type="checkbox"/> Other:	ICD10 Code:

REQUIRED DOCUMENTATION/TESTING	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> Hepatitis B Test Results: HBsAg, Total HepB Core Antibody	<input type="checkbox"/> TB Test Results

List Tried & Failed Therapies, including duration of treatment:

- 1)
- 2)
- 3)

MEDICATION ORDERS	
Initial Dosing	<input type="checkbox"/> Simponi Aria 2mg/kg IV at Week 0, 4, then every 8 weeks thereafter
Maintenance Dosing	<input type="checkbox"/> Simponi Aria 2mg/kg IV every 8 weeks <input type="checkbox"/> OTHER: Simponi Aria _____ IV every _____ weeks
Refills:	<input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> _____ doses
<ul style="list-style-type: none">• New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.• Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.	

PREMEDICATIONS	
<input checked="" type="checkbox"/> Acetaminophen 1000mg PO prior to Simponi Aria infusion	
<input checked="" type="checkbox"/> Diphenhydramine 25mg IVP prior to Simponi Aria infusion	
<input type="checkbox"/> Other: _____	

PROVIDER INFORMATION			
Office Contact Name:			
Prescribing Providers Name:		Provider NPI:	
Office Address:	City:	State:	Zip:
Office Phone Number:		Office Fax Number:	
Physician Signature:		Date:	

Contact us with questions at: **Montgomery (334) 273-7000 or Prattville (334) 351-1000**

Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207