

# Simponi Aria (golimumab)

Provider Order Form rev. 5/20/2022



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ph: 888-209-8874 fax: 833-329-4738

## PATIENT INFORMATION

Patient Name:		DOB:	
Patient Phone:		Patient Email:	
NKDA	Allergies:	Weight lbs/kg:	Height:
<b>Patient Status:</b>	New to Therapy	Continuing Therapy	Therapy Change
	Next Due Date (if applicable):		

## PROVIDER INFORMATION

Referral Coordinator Name:		Referral Coordinator Email:	
Ordering Provider:		Provider NPI:	
Referring Practice Name:		Phone:	Fax:
Practice Address:		City:	State: Zip Code:

## DOCUMENTATION (REQUIRED)

Labs	Insurance Card (front and back)	Current Medications	History/Progress Notes
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### ICD-10 CODE

- K50.90 Crohn's/Pediatric Crohn's Disease
- M06.9 Rheumatoid arthritis
- M45.9 Ankylosing Spondylitis
- L40.50 Psoriatic Arthritis
- M08.09 Polyarticular juvenile idiopathic arthritis
- Other: \_\_\_\_\_

### MEDICATION ORDER

**Simponi Aria** (golimumab)

Dose: 2mg/kg IV  
Other: \_\_\_\_\_

Frequency:  
At week 0, 4 and every 8 weeks thereafter  
Every 8 weeks  
Other: \_\_\_\_\_

### PRE-MEDICATION ORDERS

- acetaminophen (Tylenol) 500mg 650mg 1000mg PO
- cetirizine (Zyrtec) 10mg PO
- loratadine (Claritin) 10mg PO
- diphenhydramine (Benadryl) 25mg 50mg / PO IV
- methylprednisolone (Solu-Medrol) 40mgIV 125mg IV
- hydrocortisone (Solu-Cortef) 100mg IV
- Other: \_\_\_\_\_

Order Expiration Date (mm/dd/yy): \_\_\_\_\_  
(If not indicated order will expire one year from date signature)

### SPECIAL INSTRUCTIONS

Dose: \_\_\_\_\_ Route: \_\_\_\_\_ Frequency: \_\_\_\_\_

Provider Name (Print)	Provider Signature	Date
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Check here if this is a stat order