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SIMPONI ARIA (golimumab) infusion orders

Patient Name

DOB

Phone

M

F

DIAGNOSIS *Please provide ICD-10 code*

Rheumatoid Arthritis

Active Psoriatic Arthritis (PSA)

(other)

Active Ankylosing Spondylitis (AS)

PRE-MEDICATION

Tylenol 1000mg PO

Diphenhydramine 25mg PO

Cetirizine 10mg PO

Solu-Medrol 125mg IVP

Solu-Cortef 100mg IVP

Diphenhydramine 25mg IVP

(other)

(other)

SIMPONIA ARIA ORDERS

DOSAGE

2 mg/kg *(weight-based)*

mg *(flat dose)*

PATIENT WEIGHT

lbs.

kg

FREQUENCY

every 0,4, and every 8 weeks *(induction)*

every _____ weeks

NOTES

ORDERING PROVIDER

Signature **X**

Date

Provider

Phone

Fax