CURBSIDE
INFUSION SERVICES

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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)
☐ _____ Active Ankylosing Spondylitis (AS)
☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ _____ *(other)*

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____ *(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 *(maintenance)*

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____