Golimumab (Simponi Aria)

Provider Order Form *rev. 08/21/2023*

IVX HEALTH

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation **NOTE:** IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 05.01.2023)

☑ TB status and date (Please provide results)

_____

☑ Hepatitis B status and date (Please provide results)

_____

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) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

SPECIAL INSTRUCTIONS

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

THERAPY ADMINISTRATION

☑ **Golimumab** (Simponi Aria) in 100ml 0.9% sodium chloride, intravenous infusion over 30 minutes (use in line filter 0.22 micron or less)

- Dose: ☐ 2mg/kg / ☐ other _____mg/kg
- Frequency: ☐ induction: week 0, and 4, and then every 8 weeks / ☐ maintenance: every 8 weeks / ☐ other: _____
- Duration: Infuse over 30 minutes

☑ Flush with 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 30-minute observation period
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

Perform test for latent TB; if positive, start TB treatment prior to starting SIMPONI ARIA. Monitor all patients for active TB during treatment, even if initial latent TB test is negative. Prior to initiating SIMPONI ARIA, test patients for hepatitis B viral infection. All patients should be tested for HBV infection before initiating TNF-blocker therapy.

Provider Name (Print) **Provider Signature** **Date**

FAX NUMBERS

☐ AUSTIN: 512-772-2824	☐ CONNECTICUT: 860-955-1532	☐ INDIANAPOLIS: 844-983-2028	☐ NORTH CENTRAL FL: 352-756-4191	☐ RALEIGH: 919-287-2551
☐ BAY AREA: 844-889-0275	☐ DAYTONA: 386-259-6096	☐ JACKSONVILLE: 904-212-2338	☐ NORTH JERSEY: 551-227-2823	☐ SAN ANTONIO: 726-238-9950
☐ CHARLOTTE: 336-663-0143	☐ DELAWARE: 302-596-8553	☐ KANSAS CITY: 844-900-1292	☐ NORTHWEST AR: 888-615-1445	☐ SARASOTA: 941-870-6550
☐ CHICAGO: 312-253-7244	☐ EAST TN: 615-425-7427	☐ LAKELAND: 863-316-3910	☐ ORLANDO: 844-946-0867	☐ SOUTH JERSEY: 856-519-5309
☐ CINCINNATI: 844-946-0868	☐ FT. LAUDERDALE: 754-946-2052	☐ LITTLE ROCK: 501-451-5644	☐ PALM BEACH: 561-768-9044	☐ SOUTHWEST FL: 813-283-9144
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	☐ HOUSTON: 832-631-9595	☐ MIDDLE TN: 888-615-1445	☐ PIEDMONT TRIAD: 336-790-2200	☐ WEST TN: 888-615-1445