sage infusion

SIMPONI ARIA infusion orders

(golimumab)

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
- ☐ _____
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____

SIMPONI ARIA ORDERS

DOSAGE

- ○ Notify MD if patient weight changes by _____ lbs. / kg (please circle)
- ○ _____ 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 _____