

Golimumab (Simponi Aria)

Provider Order Form rev. 8/24/26



PATIENT INFORMATION

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

Patient Name: _____ DOB: _____ Mobile Phone Number: _____
Weight (lbs/kg): ☐ NKDA Allergies: _____
Therapy Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

REQUIRED SUPPORTING DOCUMENTATION (Please include the following with the order to support processing & insurance approval)

- Patient demographics • Office/progress notes supporting diagnosis including treatment failures • Labs & tests supporting diagnosis • Insurance card(s)
- TB results: If TB results are positive, provide documentation of treatment or medical clearance, and a negative CXR
- Hepatitis B results: If Hepatitis B results are positive, provide documentation of medical clearance

DIAGNOSIS ICD-10 CODE (Provider must specify)

- ☐ L40.50 Arthropathic psoriasis, unspecified ☐ L40.52 Psoriatic arthritis mutilans ☐ M06.9 Rheumatoid arthritis, unspecified
☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified ☐ M05.79 RF-positive rheumatoid arthritis, multiple sites, without organ involvement
☐ M06.89 Other specified rheumatoid arthritis, multiple sites ☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
☐ M45.0 Ankylosing spondylitis of multiple sites in spine ☐ Other: _____

PRIMARY MEDICATION ORDER

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

- Infuse over 30 minutes
- Flush with 0.9% sodium chloride at infusion completion
- ☐ Patient is required to stay for 30-minute observation
- Refill for 12 months unless otherwise noted: _____

☐ **New Start:** 2mg/kg IV at Week 0, 4, and every 8 weeks thereafter

☐ **Maintenance:** 2mg/kg IV every 8 weeks

SPECIAL INSTRUCTIONS

PRE-MEDICATION

Note: pre-meds not typically indicated for Simponi ARIA

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ famotidine (Pepcid) 20 mg IV
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ Other: _____
Dose: _____ Route: _____

LABORATORY ORDERS

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

NURSING

- Provide nursing care per Arbor Infusion Nursing Procedures, including reaction management and post-procedure observation

APPEALS PROCESS

Upon denial, Arbor Infusion will appeal with a Letter of Medical Necessity unless you opt out: ☐ Opt out (I will manage any denial)

Ordering Provider (Print)

Provider Signature

Provider NPI

Date

☐ No change to practice information since the most recent referral or order. If checked, the additional practice information section below may be left blank.

PRACTICE INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zipcode: _____

ARBOR INFUSION FAX NUMBERS (Submit a signed order and supporting documentation via fax or email orders@arborinfusion.com)

- ☐ Arbor Infusion Fishers (317) 981-1772