



Checklist for Simponi Aria (golimumab) Referral

Patient Name: _____ DOB: _____ Date: _____

Referring Physician: _____ NPI: _____

Referring Office Contact/Title: _____

Office Address: _____

Office Phone: _____ Office Fax: _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- Patient demographic information
- Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- Supporting clinical notes and office visits. Two notes preferred.
 - Note should include any therapies tried/failed, and must include discussion about Simponi Aria
 - Medication list and allergies
- Supporting lab reports/orders for Simponi Aria treatment
 - *Required Baseline:* TB screening, HBV screening, CBC w diff
 - *Recommended:* periodic CBC w diff
- Simponi Aria Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible --

Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 ext. 112

Visit our website: www.InfusionCenterNE.com

Email: info@infusioncenterne.com

Infusion Center of New England

9 Payson Road, Suite 100, Foxboro MA 02035

Ph: 781-551-5812

Fax: 508-698-8671



Prescribing Order: Simponi Aria (golimumab)

Date of Order: _____

New Start Maintenance

Date of last infusion: _____

Patient Name: _____ DOB: _____ M/F: _____

Diagnosis (include ICD-10 code/s): _____

NKDA Allergies: _____

Patient Weight: _____

Premedication:

- Acetaminophen 1000mg PO
- Loratadine 10mg or Cetirizine 10mg PO
- Diphenhydramine 25mg PO
- Diphenhydramine 25mg IV
- Solu-medrol 125mg IV
- Other: _____

Lab Orders:

- CBC w/diff every _____ weeks
- CMP every _____ weeks
- Other: _____

Entyvio Medication Order

Dosing: Simponi Aria 2mg/kg IV

Frequency: Dose at week 0, 4 and 8 Maintenance dose every 8 weeks thereafter

Administration:

- ✓ Dilute Simponi Aria in 100ml 0.9% Sodium Chloride. Administer intravenously over 30 min
- ✓ Do not administer if patient has active signs or symptoms of infection.
- ✓ Do not administer in patient with signs/symptoms of CHF, TB, or hepatitis
- ✓ In case of infusion reaction, STOP infusion and follow ICNE infusion reaction protocol. Notify physician.

Ordering Provider Name

NPI

Signature

Date