INFUSION CENTER OF NEW ENGLAND

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 option 4

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**

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