Simponi Aria Order

(Golimumab)

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

*Please fax a copy of the following patient information:
❒ Demographics ❒ Insurance Information ❒ Current Medications
❒ H & P Relevant to Diagnosis ❒ Current CBC & CMP ❒ TB Results
❒ Hep B Results

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: _____

ICD-10: _____

TB Test Date: _____ Result: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

Hep B Date: _____ Result: _____

PRE-MEDICATIONS:

Benadryl:	❒ PO	❒ IV	❒ 25mg	❒ 50mg	❒ Pre-med	❒ PRN
Acetaminophen:	❒ PO			❒ 650mg	❒ Pre-med	❒ PRN
❍Olaritin or ❍Zyrtec	❒ PO		❒ 10mg		❒ Pre-med	❒ PRN
Solu-Medrol:		❒ IV	❒ _____ mg		❒ Pre-med	❒ PRN
Normal Saline:		❒ IV	❒ 250mL		❒ Pre-med	❒ PRN
Zofran:	❒ PO	❒ IV	❒ _____ mg		❒ Pre-med	❒ PRN

SIMPONI ARIA (GOLIMUMAB) IV DOSAGE

Date of Last Treatment, If Continuation:

50mg / vial

Total Dose: _____ mg (2mg / kg) Initial dose at 0. 4 weeks. <u>then</u> Q 8 weeks

Start on: _____