(golimumab)

SIMPONI ARIA infusion orders

Patient Name _____ DOB _____

Phone _____ M ○ F ○

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Rheumatoid Arthritis

☐ _____ _____
(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

○ 2 mg/kg *(weight-based)*
○ _____ 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 _____

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