INFUSE ONE

(golimumab)

SIMPONI ARIA infusion orders

Patient Name   DOB

Phone   M   F

DIAGNOSIS *Please provide ICD-10 code*

Rheumatoid Arthritis

Active Psoriatic Arthritis (PSA)   *(other)*

Active Ankylosing Spondylitis (AS)

PRE-MEDICATION

Tylenol 1000mg PO   Solu-Medrol 125mg IVP

Diphenhydramine 25mg PO   Solu-Cortef 100mg IVP

Cetirizine 10mg PO   Diphenhydramine 25mg IVP

(other)   *(other)*

SIMPONIA ARIA ORDERS

DOSAGE   **PATIENT WEIGHT**

2 mg/kg   *(weight-based)*   lbs.

mg   *(flat dose)*   kg

FREQUENCY

every 0,4, and every 8 weeks   *(induction)*

every   weeks

NOTES

ORDERING PROVIDER

Signature **X**_____ Date

Provider   Phone   Fax