MIC | METRO INFUSION CENTER

INFUSION ORDERS-SIMPONI ARIA (GOLIMUMAB)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Date of Referral:

REFERRAL STATUS
☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location*:

*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE	
☐ Moderate to Severe Rheumatoid Arthritis (RA)	ICD 10 Code: M06.9
☐ Active Psoriatic Arthritis	ICD 10 Code: L40.52
☐ Active Ankylosing Spondylitis	ICD 10 Code: M45.9
☐ Other Diagnosis: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
☐ This signed order form by the provider ☐ Patient demographics AND insurance information ☐ TB Test Results	☐ Clinical/Progress notes supporting primary diagnosis ☐ Labs and Tests supporting primary diagnosis ☐ Hepatitis B Test Results: HBsAg & Total HepB Core Antibody
List Tried & Failed Therapies, including duration of treatment: 1) 2) 3)	

MEDICATION ORDERS	
Initial Dosing	☐ Simponi Aria 2mg/kg IV at Week 0, 4 then every 8 weeks thereafter
Maintenance Dosing	☐ Simponi Aria 2mg/kg IV every 8 weeks ☐ Other: Simponi Aria _____ IV every _____ weeks
Patient Weight = _____ kg	
Refills: ☐ X 6 months ☐ X 1 year ☐ _____ doses	

PHYSICIAN INFORMATION		
Prescribing Physician:		
Office Phone:	Office Fax:	Office Email:
Physician Signature:		Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164