Infusion ASSOCIATES

Phone: (833) 394-0600 Fax: (833) 996-4888

Simponi Aria IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, Current Medications and **Recent Visit Notes***

Referral status: ☐ NEW referral ☐ Dose or frequency change ☐ Order renewal

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

ICD-10 : _____, _____, _____

In the past year, what medications for the above diagnosis has the patient tried and failed?

Drug	Dose	Dates of use

TB verification ***(circle one):*** **TB skin test** **TB spot/Quantiferon blood test** **Chest X-RAY**

Result Date: _____/_____/_____ Result ***(circle one):*** **Positive** **Negative**

Labs to be collected: ☐BMP ☐CMP ☐CBC w/o diff ☐CBC w/diff ☐CBC w/man diff ☐CRP ☐ESR ☐ _____

Lab Frequency: ☐ EVERY infusion ☐ Every OTHER infusion ☐_____

Simponi Aria (golimumab) IV

☐ **2mg/kg** ☐ **_____mg**

Frequency: ☐ **Initial doses 0,4 wks THEN q 8 wks**
☐ **q 8 weeks**
☐ **q_____weeks**

Printed provider name: _____

Provider signature: _____

Office phone number: _____ **Fax number:** _____

New referring providers, how did you hear about us? ☐Web Search ☐Pharma Rep ☐ Drug Locator ☐Patient ☐Word of Mouth ☐IA Clinical Liaison ☐IA Website ☐Facebook ☐Instagram ☐ Other: _____