PRESCRIPTION ORDER FORM

SIMPONI ARIA

(golimumab)

Suite Life
Infusing health and wellness into your life.

Central Fax: 800-504-0870

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- CBC
- Tried/Failed Therapies
- Negative TB Results
- HEP B Panel
- Medication List

PRIMARY DIAGNOSIS

- ☐ L40.50 Athropathic psoriasis, unspecified
- ☐ L40.52 Psoriatic arthritis mutilans
- ☐ M05.79 Rheumatoid arthritis with rheumatoid factor multiple sites without organ/system involvement
- ☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified
- ☐ M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
- ☐ M06.89 Other specified rheumatoid arthritis, multiple sites
- ☐ M06.9 Rheumatoid arthritis, unspecified
- ☐ M45.0 Ankylosing spondylitis of multiple sites in spine
- ☐ Other: _____

CLINICAL MONITORING: Recommened lab to be maintained and monitored by prescriber

☐ CBC Periodically

PRE-MEDICATIONS: No Standard premedications typically indicated

- ☐ Diphenhydramine 25mg PO
- ☐ Diphenhydramine 50mg PO
- ☐ Diphenhydramine 25mg IVP
- ☐ Diphenhydramine 50mg IVP
- ☐ Pepcid 20mg PO
- ☐ Pepcid 20mg IVP
- ☐ Ceritrizine 10mg PO
- ☐ Tylenol 650mg PO
- ☐ Solu-medrol 40mg IVP
- ☐ Solu-medrol 125mg IVP
- ☐ Other: _____

PRIMARY MEDICATION ORDER: If necessary, Suite Life will round dose up/down according to payor guidelines

☐ Simponi ARIA 2mg/kg (_____mg) IV at week 0,4, and every 8 weeks thereafter

☐ Simponi ARIA ___ mg/kg (____mg) every _____ weeks.

☐ Other: _____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)

☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____

Provider Signature Date

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