

Fax form to:

Billings - 406.206.0105
Great Falls - 406.794.0555
Boise - 208.545.3214

Colorado Springs - 719.623.0085
Grand Junction - 970.404.8100

INFUSION ORDERS SYMPONI ARIA (golimumab)

Patient's Information

Date of Referral

First Name

Last Name

M.I.

Date of Birth

Address

City

State

ZIP Code

Phone

WT (kg)

HT (in)

Diagnosis

Allergies

***Please fax all recent labs including TB date/results and Hepatitis B Ag date/results.**

*ICD 10 CODE

*** Please include supporting clinical documentation for the specified ICD 10 Code as well as demographic and insurance information. This is necessary to ensure payment by the insurance carrier. Please fax with this order form. Initial appointment date and time will be verified after insurance approval.**

SYMPONI ARIA DOSING

2mg/kg IV x 1 on week 0,4, then every 8 weeks thereafter

Frequency

Loading dose of day 0, 2 weeks, 6 weeks, and every 8 weeks thereafter

Specific dosing frequency of

Refills:

Premedications

Prescribing Provider

Address

City

State

ZIP Code

Provider
Signature

Date

Provider Phone

Provider Fax