

Phone: 800-809-1265

MRN: _____

DOB: _____

STANDARD Simponi ARIA® (golimumab for infusion) PLAN OF TREATMENT

(Re)Certification Period from _____ to _____

NOTE: Patient is *ineligible* to receive Simponi Aria if receiving antibiotic for active infectious process (due to the possibility of developing a super-infection related to its effect on the immune status), or if he/she has a suspected infection.

Patient's Name _____ **HT:** _____ **WT:** _____ **Allergies:** _____

- Diagnosis:** 714.0 Rheumatoid Arthritis
 714.2 Rheumatoid Arthritis with visceral or systemic involvement

Physician Office to Complete:

1. Has your patient had failure, intolerance, or contraindication to conventional therapy?
 Yes No
2. If yes, please specify, treatment/medication tried and outcomes: _____

3. Is patient currently on methotrexate therapy? Yes No

Obtain weight each visit. Vital signs baseline then 30 minutes post infusion for the first 3 treatments, then may discharge after infusion. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient for response to therapy. Supplies needed to complete prescribed therapy.

If adverse drug reaction, implement the Standing Adverse Reaction Protocol.

Drug:

Loading dose:

- Simponi ARIA 2 mg/kg, infuse over 30 minutes, at week 0 and 4

Maintenance Dose as follows:

- Simponi ARIA 2mg/kg every 8 weeks

Pharmacist to perform clinical drug monitoring

(no stamped signatures please)

Physician's Signature: _____ Date: _____
 (Dispense as written) (Substitution permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920

Patient should have a negative PPD within 6 months, documented absence of active TB, as well as documented Hep B surface antigen.

- Does the patient have a history of (circle each): TB SOB Cough Night Sweats Fever Weight Loss None
 Has the patient had recent exposure to TB or been out of the country in the past month? Yes No
 Does the patient have a family history of TB? Yes No Chest X-Ray: Yes No Results: _____
 Has the patient had a PPD test? Yes No Date _____ Results _____ **Palmetto must have copy on file**
 Any previous treatment for TB? Yes No
 Has patient received **TNF therapy in past 6 months?** Yes No Therapy: _____ Last date Received: _____
 Hep B surface antigen drawn: Yes No Please fax results with referral along with PPD results