

Simponi Aria (golimumab)

Provider Order Form rev. 1/12/2026



AMERICAN
INFUSION CARE

SPECIALTY INFUSION

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Full Name: _____ DOB: _____ Phone: _____ Gender: ☐ M ☐ F ☐ Other

Email Address: _____ Address: _____ Weight (lbs/kg): _____ Height (in): _____

☐ NKDA Allergies: _____ Existing prior authorization? ☐ Yes, (Send a copy) ☐ No (AIC will process)

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Patient Preferred Location: _____

DIAGNOSIS & CLINICAL INFORMATION

ICD 10-Code & Description (Provide full completed code)

- ☐ L40.50 Arthropathic 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: _____

REQUIRED DOCUMENTATION: Please include insurance card (front & back), all patient demographics, history & physicals, medication lists, recent lab results (CBC, CMP, TB, Hep B panel-depending on medication), signed prescription order and recent visit notes.

Confirm that these and the required lab orders have been sent to American Infusion Care and necessary parties.

PRESCRIPTION INFORMATION

Nursing: Provide nursing care per American Infusion Care - Specialty Infusions protocols, including reaction management and post-procedure observation

Pre-Medications

- ☐ Acetaminophen (Tylenol) ☐ 500mg ☐ 650mg ☐ 1000mgPO
☐ Cetirizine (Zyrtec) 10mgPO
☐ Loratadine (Claritin) 10mgPO
☐ Diphenhydramine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV
☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 125mg IV
☐ Other: _____ Dose: _____ Route: _____

Lab Orders

Required: Hep B Core, TB Results, Hep B Surface Antigen

☐ Other: _____

Simponi Aria (golimumab) (Select one):

Initial Dose: ☐ Infuse 2 mg/kg IV over 30 minutes on Weeks 0 and 4.

☐ Other: _____

Maintenance Dose: ☐ Infuse 2 mg/kg IV over 30 minutes every 8 weeks.

☐ Other: _____

****Dispense quantity sufficient of 50mg single dose vials for each dose. Round to nearest 12.5mg increment.**

Post Treatment Observations: The patient is required to stay for 30 minutes following the first administration.

☐ Refills: ☐ zero ☐ 6 months ☐ 12 months ☐ _____ (Prescription valid for one year, unless otherwise indicated)

Special Instructions: _____

PROVIDER INFORMATION

Provider Full Name: _____ Provider NPI #: _____ Specialty: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____

Provider Name (Print)

Provider Signature

Date

E: Referrals@americaninfusioncare.com
Americaninfusioncare.com

Greater Houston Area F: 832.510.7824 P: 832.800.3213
McAllen F: 956.302.8906 P: 832.800.3213 Plano: F: 214.831.9829 P: 972.865.4454
Harlingen F: 956.341.9687 P: 832.800.3213 Laredo F: 956.306.3715 P: 832.800.3213
Other Locations (Oaklawn, Lancaster, etc): F: 469.305.2361 P: 972.865.4454