

KabaFusion
Patient-Focused Infusion Therapy

## SIMPONI ARIA (GOLIMUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET

| Patient Information   |        |  |  |  |   |        |  |
|---|--------|--|--|--|---|--------|--|
| Patient Name:   |        |  |  | Date:  |   |        |  |
| DOB:  |        |  |  | Height:  | ☐ inches ☐ cm   |        |  |
| Allergies:  |        |  |  | Weight:  | ☐ lbs ☐ kg  |        |  |
| Primary Diagnosis   |        |  |  |  |   |        |  |
| Diagnosis ICD-10 Diagnosis  |        |  |  |  | ICD-10  |        |  |
| ☐ Rheumatoid arthritis  | M45    |  | ritis with   | rheumatoid factor, unspecified   |   | M05.9  |  |
| ☐ Rheumatoid arthritis, unspecified   | M06.9  | ☐ Rheumatoid arthritis w/o rheumatoid factor, unspecil |  |  |   | M06.00 |  |
| ☐ Juvenile rheumatoid polyarthritis (seronegative)  | M08.3  | ☐ Other juvenile ar                                    | Other juvenile arthritis, unspecified site   |  |   | M08.80 |  |
| ☐ Psoriatic Arthritis   | L40.52 | ☐ Other:   | , , , , , , , , , , , , , , , , , , ,  |  |   | 1      |  |
| ☐ Ankylosing Spondylitis  | M45    |  |  |  |   |        |  |
| Medication Order  |        |  |  |  |   |        |  |
| Simponi Aria (Golimumab):  2mg/kg IV at weeks 0,4 and then every 8 weeks x 1 year (initial dosing)  2mg/kg IV every 8 weeks x 1 year  Other  Infusion will be administered over 30 minutes  Skilled nursing to assess and administer and/or teach self-administration where appropriate via access device as indicated below. Nursing will provide ongoing support as needed. |        |  |  |  | ☐ Refills x one year from date of signature unless indicated below  ☐ Refills |        |  |
| Ancillary Orders  |        |  |  |  |   |        |  |
| Pre-medications:  ☐ Diphenhydramine: 25mg PO 30 min pre-infusion ☐ Acetaminophen: 650mg PO 30 min pre-infusion ☐ Famotidine: 20 mg PO x1 dose ☐ Other pre-meds: ☐ CVAD: NS 5  |        |  |  | : NS 1-3 mL before/after use<br>VAD: NS 5 to 10 mL before/after use and 10 mL<br>raw. Heparin (100 unit/mL) 3 to 5 mL final flush<br>5 to 10 mL before/after use and 10 mL post-lab draw<br>LO units/mL) 3 to 5 mL final flush |   |        |  |
| ☐ Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack: Adult: 0.3mg Children: 0.15 mg Administer epinephrine IM in the event of anaphylaxis. May repeat x 1 as needed, Call 911. Refill x 1yr   |        |  |  |  |   |        |  |
| Therapy Specific Documentation  |        |  | Other Required Documentation   |  |   |        |  |
| Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:  Hepatitis B Surface Antigen Hepatitis B Core Antibody Total (not Core IgM) QuantiFERON TB Other:  |        |  | <ul> <li>□ Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise.</li> <li>□ H&amp;P OR progress note(s)</li> <li>□ Medication List - please list past and present DMARDS and biologics below with dates of discontinue, if applicable</li> </ul> |  |   |        |  |
| Provider Information  |        |  |  |  |   |        |  |
| Provider Name:  |        |  | Provider Phone:  |  |   |        |  |
| Provider NPI:   |        |  | Provider Fax:  |  |   |        |  |
| Provider Address:   |        |  |  |  |   |        |  |
| authorize KabaFusion and its representatives to act as an agent and initiate and execute any insurance prior authorization process for this prescription and any future refills of the same prescription  |        |  |  |  |   |        |  |

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for the patient listed above. I understand that I can revoke this designation at any time by providing written notice to KabaFusion.

Prescriber Signature: \_\_\_

Date: \_\_\_\_\_