

SIMPONI ARIA (GOLIMUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET

	Pati	ent Information				
Patient Name:			Date:			
DOB:			Height:	🗅 inches 🗅 cm		
Allergies:			Weight:	🗆 lbs 🖵 kg		
Primary Diagnosis						
Diagnosis ICD-10 Diagnosis				ICD-10		
Rheumatoid arthritis	M45	Rheumatoid arthritis w	Rheumatoid arthritis with rheumatoid factor, unspecified M05.9			
Rheumatoid arthritis, unspecified	M06.9	Rheumatoid arthritis w	theumatoid arthritis w/o rheumatoid factor, unspecified M06.00			
Juvenile rheumatoid polyarthritis (seronegative)	M08.3	Other juvenile arthritis	her juvenile arthritis, unspecified site M08.80			
Psoriatic Arthritis	L40.52	Giller:				
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				from date signature indicated	 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:	Implanted VAD post-lab draw. H	 IV Flush Orders: Peripheral: NS 1-3 mL before/after use Implanted VAD: NS 5 to 10 mL before/after use and 10 mL post-lab draw. Heparin (100 unit/mL) 3 to 5 mL final flush CVAD: NS 5 to 10 mL before/after use and 10 mL post-lab draw Heparin (10 units/mL) 3 to 5 mL final flush Refill x one year 				
Refill x one year		Heparin (10 uni	10 mL before/after use and 10 ts/mL) 3 to 5 mL final flush		aw	
 Refill x one year Anaphylaxis Protocol: Epinephrine Auto-Injector dua Administer epinephrine IM in the event of anaphylaxis 	•	Heparin (10 uni Refill x one yea 0.3mg Children: 0.15 mg	10 mL before/after use and 10 its/mL) 3 to 5 mL final flush r		aw	
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 Anaphylaxis Protocol: Epinephrine Auto-Injector dua Administer epinephrine IM in the event of anaphylaxis Therapy Specific Documentation Please include the following lab results required for infu are available, the following labs will be drawn prior to f Hepatitis B Surface Antigen Hepatitis B Core Antibody Total (not Core IgM) QuantiFERON TB 	. May repeat x usion. If no res irst infusion:	Heparin (10 uni Refill x one year 0.3mg Children: 0.15 mg (1 as needed, Call 911. Refined sults Builts H&P OR progre Medication List	10 mL before/after use and 10 its/mL) 3 to 5 mL final flush r effill x 1yr Other Required Document raphics – include insurance in ation unless the insurance di ss note(s) - please list past and present) mL post-lab dr ntation formation. We v ctates otherwise : DMARDS and	will	
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I 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 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: _____

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