

SIMPONI ARIA (GOLIMUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET

	Pat	tient Information				
Patient Name:			Date:	Date:		
DOB:			Height:	🗅 inches 🕒 cm		
Allergies:			Weight:	🗆 lbs 🖵 kg	🗆 lbs 🖵 kg	
Primary Diagnosis						
Diagnosis ICD-10 Diagnosis			sis ICD-10		ICD-10	
Rheumatoid arthritis	M45	Rheumatoid arthritis with rheumatoid factor, unspe		nspecified	M05.9	
Rheumatoid arthritis, unspecified	M06.9	🖵 Rheumatoid ar	Rheumatoid arthritis w/o rheumatoid factor, unspecified M0		M06.00	
Juvenile rheumatoid polyarthritis (seronegative)	M08.3	Dther juvenile	Other juvenile arthritis, unspecified site M08.80		M08.80	
Psoriatic Arthritis	L40.52	Dther:				
Ankylosing Spondylitis	M45					
Medication Order						
Simponi Aria (Golimumab): ² 2mg/kg IV at weeks 0,4 and then every 8 weeks x 1 year (initial dosing) ² 2mg/kg IV every 8 weeks x 1 year ³ 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: Refill x one year			 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 			
 Acetaminophen: 650mg PO 30 min pre-infusion Famotidine: 20 mg PO x1 dose Other pre-meds:		 Implant post-lab CVAD: N Heparin 	ral: NS 1-3 mL before/after use ed VAD: NS 5 to 10 mL before/aft draw. Heparin (100 unit/mL) 3 t S 5 to 10 mL before/after use an (10 units/mL) 3 to 5 mL final flux	o 5 mL final flush d 10 mL post-lab dr	aw	
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 Acetaminophen: 650mg PO 30 min pre-infusion Famotidine: 20 mg PO x1 dose Other pre-meds: Refill x one year Anaphylaxis Protocol: Epinephrine Auto-Injector dual 	-	Implant post-lab CVAD: N Heparin Refill x o : 0.3mg Children: 0	ral: NS 1-3 mL before/after use ed VAD: NS 5 to 10 mL before/aft draw. Heparin (100 unit/mL) 3 t S 5 to 10 mL before/after use an (10 units/mL) 3 to 5 mL final flue one year 15 mg	o 5 mL final flush d 10 mL post-lab dr h	aw	
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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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