



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
			oid arthritis with rheumatoid factor, unspecified		M05.9
☐ Rheumatoid arthritis, unspecified	M06.9	☐ Rheumatoid arth		M06.00	
☐ Juvenile rheumatoid polyarthritis (seronegative)	M08.3		thritis, unspecified site		M08.80
☐ Psoriatic Arthritis	L40.52	☐ Other:	☐ Other:		
☐ Ankylosing Spondylitis	M45				
Medication Order					
Simponi Aria (Golimumab): 2 mg/kg IV at weeks 0,4 and then every 8 weeks x 1 year (initial dosing) 2 mg/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				Refills x one year from date of signature unless indicated below	
below. Nursing will provide ongoing support as needed.				Refills	
Ancillary Orders					
□ 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		
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:			 □ Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise. □ H&P OR progress note(s) □ Medication List - please list past and present DMARDS and biologics below with dates of discontinue, if applicable 		
Provider Information					
Provider Name:			Provider Phone:		
Provider NPI:			Provider Fax:		
Provider Address:					
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					

CONFIDENTIALITY NOTICE: The following includes confidential, proprietary information that is the sole exclusive property of KabaFusion Holdings, LLC. No rights in, relating to, or derived from such information are assigned or otherwise transferred by this document, and the recipient of such information is subject to obligations of secrecy to and for the benefit of KabaFusion Holdings, LLC. Any unauthorized use or disclosure of such information is strictly prohibited. This message, together with any attachments, is intended only for the use of the individual or entity to which it is addressed and may contain information that is confidential and prohibited from disclosure. If you are not the intended recipient, you are hereby notified that any dissemination, or copying of this message, or any attachment, is strictly prohibited. If you have received this message in error, please notify the original sender immediately by telephone or by return fax and shred this document along with any other documents. Thank you.

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: _____