

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

Patient Information			
<b>Patient Name:</b>		<b>Date:</b>	
<b>DOB:</b>		<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm
<b>Allergies:</b>		<b>Weight:</b>	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Primary Diagnosis			
Diagnosis	ICD-10	Diagnosis	ICD-10
<input type="checkbox"/> Rheumatoid arthritis	M45	<input type="checkbox"/> Rheumatoid arthritis with rheumatoid factor, unspecified	M05.9
<input type="checkbox"/> Rheumatoid arthritis, unspecified	M06.9	<input type="checkbox"/> Rheumatoid arthritis w/o rheumatoid factor, unspecified	M06.00
<input type="checkbox"/> Juvenile rheumatoid polyarthritis (seronegative)	M08.3	<input type="checkbox"/> Other juvenile arthritis, unspecified site	M08.80
<input type="checkbox"/> Psoriatic Arthritis	L40.52	<input type="checkbox"/> Other:	
<input type="checkbox"/> Ankylosing Spondylitis	M45		

Medication Order	
<b>Simponi Aria (Golimumab):</b> <input type="checkbox"/> 2mg/kg IV at weeks 0,4 and then every 8 weeks x 1 year (initial dosing) <input type="checkbox"/> 2mg/kg IV every 8 weeks x 1 year <input type="checkbox"/> Other _____  Infusion will be administered over 30 minutes <b>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.</b>	<input type="checkbox"/> Refills x one year from date of signature unless indicated below   <input type="checkbox"/> _____ Refills

Ancillary Orders	
<b>Pre-medications:</b> <input type="checkbox"/> Diphenhydramine: 25mg PO 30 min pre-infusion <input type="checkbox"/> Acetaminophen: 650mg PO 30 min pre-infusion <input type="checkbox"/> Famotidine: 20 mg PO x1 dose <input type="checkbox"/> Other pre-meds: _____ <input type="checkbox"/> <b>Refill x one year</b>	<b>IV Flush Orders:</b> <input type="checkbox"/> Peripheral: NS 1-3 mL before/after use <input type="checkbox"/> 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 <input type="checkbox"/> 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 <input type="checkbox"/> <b>Refill x one year</b>
<input type="checkbox"/> <b>Anaphylaxis Protocol: Epinephrine Auto-Injector dual pack:</b> Adult: 0.3mg Children: 0.15 mg Administer epinephrine IM in the event of anaphylaxis. May repeat x 1 as needed, Call 911. <b>Refill x 1yr</b>	

Therapy Specific Documentation	Other Required Documentation
<b>Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:</b> <input type="checkbox"/> Hepatitis B Surface Antigen <input type="checkbox"/> Hepatitis B Core Antibody Total (not Core IgM) <input type="checkbox"/> QuantiFERON TB <input type="checkbox"/> Other:	<input type="checkbox"/> Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise. <input type="checkbox"/> H&P OR progress note(s) <input type="checkbox"/> Medication List - please list past and present DMARDS and biologics below with dates of discontinue, if applicable

Provider Information	
<b>Provider Name:</b>	<b>Provider Phone:</b>
<b>Provider NPI:</b>	<b>Provider Fax:</b>
<b>Provider Address:</b>	

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: \_\_\_\_\_