

SIMPONI ARIA (GOLIMUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET

	Pat	ient Information				
Patient Name:			Date:			
DOB:			Height:	🗆 inches 🗆	🗅 inches 🕒 cm	
Allergies:			Weight:	🗆 lbs 🖵 kg	🗆 lbs 🖵 kg	
Primary Diagnosis						
Diagnosis ICD-10 Diagnosis					ICD-10	
Rheumatoid arthritis	M45 🛛 Rheumatoid arthritis with rheu			heumatoid factor, unspecified M05.9		
Rheumatoid arthritis, unspecified	M06.9	Rheumatoid arth	unspecified	M06.00		
Juvenile rheumatoid polyarthritis (seronegative)	M08.3	Other juvenile ar	ther juvenile arthritis, unspecified site			
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 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. 				from dat signature indicated	 Refills x one year from date of signature unless indicated below Refills 	
Ancillary Orders						
 Diphenhydramine: 25mg PO 30 min pre-infusion Acetaminophen: 650mg PO 30 min pre-infusion Im Famotidine: 20 mg PO x1 dose Other pre-meds: Refill x one year 			 V 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 Name: Provider NPI:			Provider Phone: Provider Fax:			

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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