



SIMPONI ARIA (GOLIMUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET

Patient Name: Date:	Patient Information						
DOB: Allergies: Primary Diagnosis Diagnosis Diagnosis Primary Diagnosis Diagnosis Diagnosis ICD-10 Diagnosis				Date:			
Primary Diagnosis ICD-10 Diagnosis Diagnosis ICD-10 Diagnosis					□ inches □ cm		
Primary Diagnosis ICD-10 MA5 MA5 Rheumatoid arthritis with rheumatoid factor, unspecified M06.9 Rheumatoid arthritis, unspecified M06.00 M06.9 Rheumatoid arthritis w/o rheumatoid factor, unspecified M06.00 M06.80 Other juvenile arthritis, unspecified site M06.80 M06.80 Other juvenile arthritis, unspecified site M06.80 M08.80 Other juvenile arthritis, unspecified site M06.80 M08.80 Other juvenile arthritis, unspecified site M06.80 M08.80 Other juvenile arthritis, unspecified site M08.80 M							
Diagnosis ICD-10 Diagnosis ICD-10 Diagnosis ICD-10 Rehumatoid arthritis with rheumatoid factor, unspecified M05.9 Rheumatoid arthritis w/o rheumatoid factor, unspecified M05.9 M06.90 M06.90 M06.90 Rheumatoid arthritis w/o rheumatoid factor, unspecified M05.90 M06.90 M06							
Rheumatoid arthritis							
Rheumatoid arthritis, unspecified M06.9 Rheumatoid arthritis w/o rheumatoid factor, unspecified M06.00 Diverelle rheumatoid polyarthritis (seronegative) M08.3 Other juvenile arthritis, unspecified site M08.80 Psoriatic Arthritis L40.52 Other: Ankylosing Spondylitis M45 M45 Medication Order Simponi Aria (Golimumab): Refills x one year from date of signature unless indicated below 2 mg/kg IV at weeks 0.4 and then every 8 weeks x 1 year (initial dosing) Refills x one year from date of signature unless indicated below 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 Refills vorders Pre-medications: IV Flush Orders: Peripheral: NS 1-3 ml. before/after use Other pre-medications: IV Flush Orders: Peripheral: NS 1-3 ml. before/after use and 10 ml. post-lab draw. Heparin (100 unit/ml.) 3 to 5 ml. final flush CAVAD: NS 5 to 10 ml. before/after use and 10 ml. post-lab draw. Heparin (100 unit/ml.) 3 to 5 ml. final flush CAVAD: NS 5 to 10 ml. before/after use and 10 ml. post-lab draw. Heparin (100 unit/ml.) 3 to 5 ml. final flush CAVAD: NS 5 to 10 ml. before/after use and 10 ml. post-lab draw. Heparin (100 unit/ml.) 3 to 5 ml. final flush CAVAD: NS 5 to 10 ml. before/after use and 10 ml. post-lab draw. Heparin (100 unit/ml.) 3 to 5 ml. final flush Refill x one year Previder New to develop the following lab results required for infusion. If no results are available, the following lab results required for infusion. If no results are available, the following lab results required for infusion. Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise. H&P OR progress note(s) Hepartits B Core Antibody Total (not Core IgM) Medication List: - please list past and present DMARDS and biologics below with dates of discontinue, if applica							
□ Juvenile rheumatoid polyarthritis (seronegative) □ Psoriatic Arthritis □ Ankylosing Spondylitis M45				, , , , , , , , , , , , , , , , , , ,			
□ Psoriatic Arthritis							
Medication Order							
Medication Order		+	a other.				
Simponi Aria (Golimumab): Refills x one year from date of signature unless indicated below Other	■ Alikyloshig spondylitis IVI45						
Administer epinephrine IM in the event of anaphylaxis. May repeat x 1 as needed, Call 911. Refill x 1yr Therapy Specific 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: Provider Information Provider Phone: Provider Phone: Provider Fax:	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				from da signatur indicate	from date of signature unless indicated below Refills and 10 mL final flush	
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							
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	Therapy Specific Documentation			Other Required Documentation			
Provider Name: Provider Phone: Provider NPI: Provider Fax:	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			□ 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			
Provider NPI: Provider Fax:	Provider Information						
	Provider Name:			Provider Phone:			
Provider Address:	Provider NPI:			Provider Fax:			

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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: _____