



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		
☐ Rheumatoid arthritis	M45	☐ Rheumatoid arthritis with rheumatoid factor, unspe						
Rheumatoid arthritis, unspecified	M06.9	-	☐ Rheumatoid arthritis w/o rheumatoid factor, unspeci					
☐ Juvenile rheumatoid polyarthritis (seronegative)	M08.3		Other juvenile arthritis, unspecified site				M08.80	
Psoriatic Arthritis	L40.52	Oth	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 below. Nursing will provide ongoing support as needed.					ated	☐ 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 post-lab draw. Heparin (100 unit/mL) 3 to 5 m CVAD: NS 5 to 10 mL before/after use and 10 Heparin (10 units/mL) 3 to 5 mL final flush Refill x one year					to 5 mL f nd 10 mL	nL final flush		
☐ 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:								
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								

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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: _____