



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

Patient Information							
Patient Name:				Date:			
DOB:				Height:	☐ inches ☐ cm		
Allergies:				Weight:			
Primary Diagnosis  Diagnosis  ICD 10  Diagnosis							
Diagnosis	ICD-10	Diagnosis			:£:l	ICD-10	
☐ Rheumatoid arthritis	M45		<ul><li>Rheumatoid arthritis with rheumatoid factor, unspec</li><li>Rheumatoid arthritis w/o rheumatoid factor, unspec</li></ul>			M05.9	
☐ Rheumatoid arthritis, unspecified	M06.9	-			<u>specifiea</u>	M06.00	
☐ Juvenile rheumatoid polyarthritis (seronegative)	M08.3		Other:			M08.80	
□ Psoriatic Arthritis	L40.52	_ u 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					from da signatur indicate	Refills x one year from date of signature unless indicated below	
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.						□ 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 u ☐ post-lab draw. Heparin (100 unit/mL) 3 to 5 m ☐ Heparin (10 units/mL) 3 to 5 mL final flush ☐ Refill x one year					o 5 mL final flush d 10 mL post-lab d	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:			<ul> <li>□ Patient Demographics – include insurance information. We will obtain authorization unless the insurance dictates otherwise.</li> <li>□ H&amp;P OR progress note(s)</li> <li>□ Medication List - please list past and present DMARDS and biologics below with dates of discontinue, if applicable</li> </ul>				
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: \_\_\_\_\_