



Patient Information						
Patient Name:			Date:			
DOB:			Height:	D inches	☐ inches ☐ cm	
Allergies:			Weight:		☐ lbs ☐ kg	
			weight.	a ibs a kg	a los a kg	
Primary Diagnosis						
Diagnosis	ICD-10	Diagnosis ICD-10				
☐ Rheumatoid arthritis	M45	☐ Rheumatoid arth	rspecified	M05.9		
☐ Rheumatoid arthritis, unspecified	M06.9	Rheumatoid arthritis w/o rheumatoid factor, unspecif		specified	M06.00	
☐ Juvenile rheumatoid polyarthritis (seronegative)	M08.3	☐ Other juvenile arthritis, unspecified site			M08.80	
☐ Psoriatic Arthritis	L40.52	☐ Other:				
☐ 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	
Ancillary Orders						
□ 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 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 NPI:			Provider Fax:			
Provider Address:						
authorize Kaha Eurian and ite representatives to act as an agent and initiate and everyte any insurance releasing to a second for this process for the process for this process for this process for the process for this process for this process for this process for the process for the process for the process for the process for this process for the						

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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: _____