KabaFusion
Patient-Focused Infusion Therapy

159 Memorial Dr. | Suite E, Shrewsbury, MA 01545
P: 888.727.2323 | eFax: 888.966.0416

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, unspecified	M05.9
❑ Rheumatoid arthritis, unspecified	M06.9	❑ Rheumatoid arthritis w/o rheumatoid factor, unspecified	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.

❑ 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 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:	

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: _____