

SIMPONI ARIA (GOLIMUMAB) PATIENT REFERRAL AND PRESCRIPTION SHEET

	Pati	ient Information				
Patient Name:			Date:			
DOB:			Height:	🗆 inches 🗳 cm		
Allergies:			Weight:	🗆 lbs 🗆 kg	🗆 lbs 🖵 kg	
Primary Diagnosis						
Diagnosis	ICD-10	Diagnosis			ICD-10	
Rheumatoid arthritis	M45	lacksquare Rheumatoid arthritis with rheumatoid factor, unspecified			M05.9	
Rheumatoid arthritis, unspecified	M06.9	Rheumatoid arthrit	Rheumatoid arthritis w/o rheumatoid factor, unspecified		M06.00	
Juvenile rheumatoid polyarthritis (seronegative)	M08.3	Other juvenile arth	Other juvenile arthritis, unspecified site M0		M08.80	
Psoriatic Arthritis	L40.52	Other:				
Ankylosing Spondylitis	M45					
Medication Order						
Simponi Aria (Golimumab):				from dat signature indicated	 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 	 Peripheral: I Implanted V post-lab dra CVAD: NS 5 Heparin (10 	 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						
	May repeat	_	-			
Therapy Specific Documentation	May repeat :	_	-	entation		
	sion. If no re	sults Patient Dem obtain auth H&P OR pro	L. Refill x 1yr Other Required Docum nographics – include insurance orization unless the insurance	information. We dictates otherwis nt DMARDS and		
Therapy Specific Documentation Please include the following lab results required for infu are available, the following labs will be drawn prior to fi Hepatitis B Surface Antigen Hepatitis B Core Antibody Total (not Core IgM) QuantiFERON TB	sion. If no re rst infusion:	sults Patient Dem obtain auth H&P OR pro	Conter Required Docum Dographics – include insurance orization unless the insurance igress note(s) List - please list past and prese	information. We dictates otherwis nt DMARDS and		
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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: _____

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