

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		ICD-10	
Rheumatoid arthritis	M45	Rheumatoid arthritis with rheumatoid factor, unspecif		unspecified	M05.9	
Rheumatoid arthritis, unspecified	M06.9	Rheumatoid arthritis w/o rheumatoid factor, unspecified		unspecified	M06.00	
Juvenile rheumatoid polyarthritis (seronegative)	M08.3	Other juvenile arthrit	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 date 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 		 Implanted VAI post-lab draw. CVAD: NS 5 to 	1-3 mL before/after use D: NS 5 to 10 mL before/ Heparin (100 unit/mL) 3 10 mL before/after use hits/mL) 3 to 5 mL final f par	after use and 10 mL 3 to 5 mL final flush and 10 mL post-lab dr	'aw	
 Diphenhydramine: 25mg PO 30 min pre-infusion Acetaminophen: 650mg PO 30 min pre-infusion Famotidine: 20 mg PO x1 dose Other pre-meds:	pack: Adult:	 Peripheral: NS Implanted VAI post-lab draw. CVAD: NS 5 to Heparin (10 ur Refill x one yee 0.3mg Children: 0.15 mg 	D: NS 5 to 10 mL before/ Heparin (100 unit/mL) 3 10 mL before/after use hits/mL) 3 to 5 mL final f har	after use and 10 mL 3 to 5 mL final flush and 10 mL post-lab dr	'aw	
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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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