

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		ICD-10
□ Rheumatoid arthritis M45 □ Rheum		Rheumatoid arthri	eumatoid arthritis with rheumatoid factor, unspecified		M05.9
Rheumatoid arthritis, unspecified	M06.9	Rheumatoid arthri	cified	M06.00	
Juvenile rheumatoid polyarthritis (seronegative)	M08.3	Other juvenile arth	Other juvenile arthritis, unspecified site MC		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				 Refills x one year from date of signature unless indicated below Refills 	
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 		
 Diphenhydramine: 25mg PO 30 min pre-infusion Acetaminophen: 650mg PO 30 min pre-infusion Famotidine: 20 mg PO x1 dose Other pre-meds:		 Peripheral: Implanted V post-lab dra CVAD: NS 5 Heparin (10) 	NS 1-3 mL before/after use /AD: NS 5 to 10 mL before/after u aw. Heparin (100 unit/mL) 3 to 5 i to 10 mL before/after use and 10 0 units/mL) 3 to 5 mL final flush	nL final flush	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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