Palmetto Infusion Services COMPLIANCE

MRN:_____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB:_____

STANDARD Simponi ARIA ® (golimumab) PLAN OF TREATMENT FOR RHEUMATOLOGY

(Re) Certification Period From_____to _____

NOTE: Patient ***may be ineligible*** to receive golimumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new or worsening symptoms of CHF, new-onset or deterioration neurological changes, and/or surgery.

1. Patient Name: _____Height (inches): _____Weight (lbs):_____

2. Allergies:_____

3. Diagnosis: *** Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing**

☐ **M05.**_____ Rheumatoid Arthritis with Rheumatoid factor ☐ **M06.**_____ Rheumatoid Arthritis without Rheumatoid factor

☐ **L40.5**_____ Psoriatic Arthropathy ☐ M**45.** _____ Ankylosing Spondylitis

☐ Other **ICD-10 Code**: _____**Diagnosis description:** _____

4. Pre-medications: ☐ None *OR* *Administered 30 minutes prior to infusion as selected:*

****Product information does not suggest premedication and suggest caution with use of Diphenhydramine due to 30-minute infusion time and safety risks with driving.***

a) Acetaminophen: □ 650mgs PO □ 500mgs PO □ 325mgs PO	b) Diphenhydramine: □ 25 mgs PO, □ 50mgs PO, □ 25 mgs IVP, □ 50mgs IVP or c) Alternate oral antihistamine to diphenhydramine: □ Cetirizine 10 mg, □ Loratadine 10 mg, Fexofenadine □ 60mgs or □ 180mgs d) Other: Methylprednisolone □ 40mgs IVP □ 125mgs IVP or other _____mgs IVP Famotidine: □ 20mgs PO, □ 40mgs PO, □ 20mgs IVP, □ 40mgs IVP

Orders: Obtain weight each visit. Instruct patient/caregiver on medications and signs/symptoms of adverse reaction. Assess patient for response to therapy. Utilize existing central line for administration or initiate a peripheral IV with each infusion as needed. Sodium Chloride 0.9% flush 3-10 ml before, after, and as needed during the infusion. Follow infusion with Heparin 100 units/ml 1 – 5 ml per line type or to peripheral IV as required for multiple day treatments. Pump, tubing, 0.22-micron filter, and supplies needed to complete prescribed therapy. **Extended 30-minute post infusion monitoring for any patient new to therapy for first 3 treatments. Pharmacist to perform clinical drug monitoring.** ***If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES.***

Dose: Simponi ARIA® (golimumab) 2 mg/kg per 100 ml Sodium Chloride 0.9% IV to infuse over at least 30 minutes

5. Frequency: _____ Induction orders to be completed at 0 week and 4 weeks, and then every 8 weeks thereafter
_____ Orders every 8 weeks (maintenance).
_____ Special Orders: _____

Lab orders with infusions: _____

6. Physician's Signature: _____/ _____Date: _____
No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____NPI: _____

7. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms available at www.palmettoinfusion.com

Revised 3/6/18

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DOB:_____

Guidelines for Prescribing Simponi ARIA® (golimumab) for Rheumatology

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

___ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-7)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

___ Include patient demographic information and insurance information. (Copy of insurance cards if available)

___ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

- SIMPONI ARIA® is a tumor necrosis factor (TNF) blocker indicated for the treatment of adult patients with:
  - Moderately to severely active Rheumatoid Arthritis (RA) in combination with methotrexate. **If the patient is unable to take methotrexate, then MD must include supporting documentation as to reason/rational.**
  - Active Psoriatic Arthritis (PsA)
  - Active Ankylosing Spondylitis (AS)

___ If patient is switching biological therapies, then MD must specify wash-out period prior to starting Simponi ARIA® as specified of _____ weeks. Last known biological therapy: _____ and last date received: _____. (Include copy of last Simponi ARIA® infusion record if available and currently on therapy)

___ Other as requested: _____
_____

Pre-Screening: (**TB and Hepatitis screening results must be available prior to start of therapy and within last 12 months.)**

___ **Required TB screening results: PPD or QuantiFERON Gold Test.**
(* If screening results are positive or indeterminate, then a negative CXR result is required.)

___ **Required Hepatitis screening to include: Hepatitis B Surface Antigen results.**

** Warnings/Precautions: **Serious Infections:** Patient should not have an active ongoing infection, signs or symptoms of malignancy, or invasive fungal infection. **Congestive Heart Failure:** If a decision is made to administer SIMPONI ARIA to RA patients with CHF, these patients should be closely monitored during therapy, and SIMPONI ARIA® should be discontinued if new or worsening symptoms of CHF appear. **Hepatitis B Reactivation:** Monitor HBV carriers during and several months after therapy. If reactivation occurs, stop SIMPONI ARIA and begin anti-viral therapy. Evaluation of immunizations should be completed prior to and live vaccines should not be given before or concurrently with Simponi ARIA ®. See full prescribing information.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.