Palmetto INFUSION®

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

Referral Status:		MRN:
☐ New referral	☐ Order change	☐ Order Renewal
Patient preferred clinic:		

Simponi ARIA® (golimumab) Standard Plan of Treatment for Rheumatology

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:			
Patient Name:		Address:			
Date of Birth:		City, State, Zip:			
Height in inches:	Weight: LB or KG	Gender:	Allergies:	☐ See list	☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	M05._____ - Rheumatoid Arthritis with Rheumatoid factor	☐	M06._____ - Rheumatoid Arthritis without Rheumatoid factor
☐	L40.5_____ - Psoriatic Arthropathy	☐	M45._____ - Ankylosing Spondylitis
☐	_____- Other:_____		

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	TB screening test results
6	HBV screening/labs as required by payor

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:
LAST INFUSION DATE:
NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

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

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV	Diphenhydramine	☐ 25mg	☐ 50mg					
	Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:				
	Famotidine	☐ 20mg	☐ 40 mg					
	Other:	☐						

PO	Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg
	Famotidine	☐ 20mg	☐ 40mg		
	Diphenhydramine	☐ 25mg	☐ 50mg		
	Fexofenadine	☐ 60mg	☐ 180mg		
	Cetirizine	☐ 10mg			
	Loratadine	☐ 10mg			
	Other:	☐			

MEDICATION/DOSE:

☑ Simponi ARIA® (golimumab) 2 mg/kg per 100 ml NS given IV to infuse over at least 30 minutes

FREQUENCY:

☐ Induction: Given at 0 week and 4 weeks, and then every 8 weeks thereafter

☐ Maintenance: Given every 8 weeks

☐ Other: _____

SPECIAL/OTHER LAB ORDERS:

☐ _____

_____

Prescriber confirms that the patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment. Prescriber to monitor patient for symptoms of HBV infection and reactivation as clinically appropriate.

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	