

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

## Simponi ARIA<sup>®</sup> (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 2<sup>ND</sup> AND 3<sup>RD</sup> 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:

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1 Insurance information	IF NO: IF YES:
2 Most recent History & Physical	PLEASE STATE LAST INFUSION DATE:
3 Full medication list	REQUIRED WASHOUT FROM PREVIOUS THERAPY: NEXT INFUSION DATE:
4 Tried and failed therapies	IF ORDER CHANGE:
5 TB screening test results	<b>Continue current order until insurance approved</b>
6 HBV screening/labs as required by payor	

### 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	Other:	PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg			Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
						Cetirizine	10mg			
				Loratadine	10mg					
				Other:						

### MEDICATION/DOSE:

Simponi ARIA<sup>®</sup> (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



# Palmetto

## INFUSION

Checklist for referrals to Palmetto Infusion:

Fax referral to 1.866.872.8920

- Patient demographics – address, phone number, SS#, etc.**
- Insurance Information – copy of the card(s) if possible**
- Plan of Treatment/Orders**
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

[www.PalmettoInfusion.com](http://www.PalmettoInfusion.com)