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) Pediatric Standard Plan of Treatment

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)

☐	M08._____ - Juvenile idiopathic arthritis (JIA), polyarticular
☐	L40.5_____ - Psoriatic Arthropathy
☐	_____- Other:_____

REQUESTED DOCUMENTATION:		PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?	
1	Insurance information	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** TB screening for new start		☐ **Continue current order until insurance approved**
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					
	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) 80 mg/m2 diluted in 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 and TB 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	