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 Garland, TX 75042
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SIMPONI ARIA (GOLIMUMAB) IV REFERRAL FORM

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Patient Weight: _____ kg ; _____ lbs

DIAGNOSIS AND ICD 10 CODE			
<input type="checkbox"/> Rheumatoid Arthritis	ICD 10 Code: _____	<input type="checkbox"/> Psoriatic Arthritis	ICD 10 Code: _____
<input type="checkbox"/> Ankylosing Spondylitis	ICD 10 Code: _____	<input type="checkbox"/> Other: _____	ICD 10 Code: _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics and Insurance Card <input type="checkbox"/> Clinical/Progress notes <input type="checkbox"/> Hepatitis B antigen	<input type="checkbox"/> Tuberculosis QFT test or a neg CXR- ANNUAL <input type="checkbox"/> Labs: Rheumatoid factor, anti citrullinated peptide, CRP/ESR <input type="checkbox"/> Last Biologic Therapy _____ <input type="checkbox"/> Washout period: # _____ of wks wait before 1st dose.
List Tried & Failed Therapies, including duration of treatment: <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> 1) 2) 3) </div> <div style="width: 35%; font-size: small;"> PA Guidance: Documented failed trial of a DMARD, NSAID, steroids like MTX, 6-MP, leflunomide. Documented failed trial of a biologic like Humira, Enbrel, Cimzia or Stelara. </div> </div>	

MEDICATION ORDERS	
Dosing	<input type="checkbox"/> Initial dose: 2mg/kg IV at week 0 and week 4 <input type="checkbox"/> Maintenance dose: 2mg/kg IV every 8 weeks
Nursing Orders	<input checked="" type="checkbox"/> Nurse to start, pause, or discontinue peripheral or central venous access device as needed <input checked="" type="checkbox"/> Flush IV line with 10-20ml saline before and after each medication dose or as needed <input checked="" type="checkbox"/> Flush PORT or Central Line with 500u/5ml Heparin as FINAL flush or as needed <input checked="" type="checkbox"/> Dispense DME pump with all necessary supplies for home infusion
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 1L 0.9% NS)	
Refills:	<input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

PRESCRIBER INFORMATION		
Prescriber Name:	NPI:	
Office Phone:	Office Fax:	Office Email:
Prescriber Signature:	Date:	

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to pharmacy@texasinfusion.com

PLEASE FAX SIGNED FORM TO 972-787-1492