



1935 W. State Street STE 103
 Garland, TX 75042
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SIMPONI ARIA (GOLIMUMAB) IV ORDER FORM

| PATIENT INFORMATION | |
|---------------------|------------------------------------|
| Name: | DOB: |
| Allergies: | Weight: _____ kg ; Height _____ in |

| 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"/> Tuberculosis QFT test or a neg CXR- ANNUAL |
| <input type="checkbox"/> Patient demographics and Insurance Card | <input type="checkbox"/> Labs: Rheumatoid factor, anti citrullinated peptide, CRP/ESR |
| <input type="checkbox"/> Clinical/Progress notes | <input type="checkbox"/> Last Biologic Therapy _____ |
| <input type="checkbox"/> Hepatitis B antigen | <input type="checkbox"/> Washout period: # _____ of wks wait before 1st dose. |
| List Tried & Failed Therapies, including duration of treatment: | |
| 1) | PA Guidance: Documented failed trial of a DMARD, NSAID, steroids like MTX, 6-MP, leflunomide. |
| 2) | Documented failed trial of a biologic like Humira, Enbrel, Cimzia or Stelara. |
| 3) | |

| 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 | 1. Nurse to start, pause, or discontinue peripheral or central venus access device as needed 2. Flush IV line with 10-20ml saline before and after each medication dose or as needed 3. Flush PORT or Central Line with 500u/5ml Heparin as FINAL flush or as needed 4. Dispense DME pump with all necessary supplies for home infusion |
| Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 500mL 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