

Golimuma

Treatment Location: Dublin, OH Lancaster, OH

PROVIDERS: Please include the following to expedite the order:

Patient Demographics, Most Recent Office Visit Note, Insurance Information, TB Test, Hep B Test

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): M06.9 L40.53 M45.9 M08.3 ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- Center will use Hypersensitivity protocol established by Infuse One Ohio
- TB Status and Date (list results & attached clinicals): _____
- Hepatitis B Status and Date (list results & attach clinicals): _____

PRE-MEDICATION ORDERS

Pre-medications not usually indicated

- Diphenhydramine 25mg / 50mg PO / IV
 - Acetaminophen 325mg / 500mg / 650mg PO
 - Other: _____
- Dose: _____ Route: _____ Frequency: _____

SPECIAL INSTRUCTIONS:

THERAPY ADMINISTRATION

- Simponi Aria Intravenous Infusion
Dose: 2mg/kg or Total Dose: _____ mg
Frequency:
 Induction: Week 0, 4, then
 Maintenance: Every 8 weeks
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, Infuse One Ohio is authorized to administer a generic or biosimilar.

Provider Name (Print)	Provider Signature	Date
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- Please check this box if you DO NOT authorize Infuse One Ohio to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.