



# SIMPONI ARIA (GOLIMUMAB) Infusion Orders

PHONE 515.225.2930 | FAX 515.559.2495

## Patient Information

Fax completed form, insurance information and clinical documentation to 515.559.2495.

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Patient Status:**      New to Therapy      Continuing Therapy      **Next Treatment Date:** \_\_\_\_\_

## Medical Information

**Diagnosis:**      Rheumatoid arthritis      Ankylosing spondylitis      Psoriatic arthritis

Other \_\_\_\_\_ **ICD-10 Code:** \_\_\_\_\_

**Patient Weight:** \_\_\_\_\_ lbs. (required)      **Allergies:** \_\_\_\_\_

## Therapy Order

### Simponi Aria:

2 mg/kg IV at weeks 0 and 4, then every 8 weeks x1 year (*initial dosing*)

2 mg/kg IV every 8 weeks x1 year      Other: \_\_\_\_\_

**Lab Orders:** \_\_\_\_\_

**Frequency:**      Every infusion      Other: \_\_\_\_\_      TB QFT screening yearly (optional)

Required labs to be drawn by:      Hy-Vee Health      Referring Provider

Other orders: \_\_\_\_\_

### Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15 mg or compounded syringe IM or Sub-Q; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50 mg orally (adult)
- Refer to physician order or institutional protocol for pediatric dosing

**Flush orders:** NS 1-20 mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

## Provider Information

By signing this form and utilizing our services, you are authorizing *Hy-Vee Health* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient.

**Provider Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider NPI:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_ **Contact Person:** \_\_\_\_\_

Opt out of Hy-Vee Health selecting site of care (if checked, please list site of care): \_\_\_\_\_

## Service Areas

Des Moines, IA      West Des Moines, IA      Chicago, IL      Omaha, NE      Buffalo, NY      Dallas, TX

Phoenix, AZ      Other \_\_\_\_\_

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# COMPREHENSIVE SUPPORT FOR SIMPONI ARIA (GOLIMUMAB) THERAPY

## Patient Information

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

## Required Documentation for Referral Processing & Insurance Approval

Include signed and completed order (MD/prescriber to complete page 1)

Include patient demographic information and insurance information

Include patient's current medication list

Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits or contraindications to conventional therapy

Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID or conventional therapy (i.e., MTX, leflunomide)?

Yes No If yes, which drug(s)? \_\_\_\_\_

Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Enbrel, Stelara, Cimzia)?

Yes No If yes, which drug(s)? \_\_\_\_\_

Include labs and/or test results to support diagnosis (**attach results**)

Rheumatoid factor

Anti-Cyclic citrullinated peptide (anti-CCP)

CRP and/or ESR

If applicable – Last known biological therapy: \_\_\_\_\_ and last date received: \_\_\_\_\_

If patient is switching to biologic therapies, please perform a washout period of

\_\_\_\_\_ weeks prior to starting Simponi Aria.

Other medical necessity: \_\_\_\_\_

## Required Prescreening

**TB screening test completed within 12 months – attach results**

**Positive Negative**

**Hepatitis B screening test completed. This includes Hepatitis B antigen and Hepatitis B core antibody total (not IgM) – attach results**

**Positive Negative**

*\*If TB or Hepatitis B results are positive, please provide documentation of treatment or medical clearance, and a negative CXR (TB+)*

Hy-Vee Health will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

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