Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Current Height: _____ Current Weight_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Related Diagnosis Code (ICD-10 code): _____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Simponi Aria® (golimumab) Treatment Plan (Rheumatology)

Patient Name: _____ **Patient DOB** _____

General

☐ Diagnosis- Rheumatoid Arthritis with Rheumatoid factor ICD-10 Code _____
☐ Diagnosis- Rheumatoid Arthritis without Rheumatoid factor ICD-10 Code _____
☐ Diagnosis- Ankylosing Spondylitis ICD-10 Code _____
☐ Diagnosis- Psoriatic Arthropathy ICD-10 Code _____
☐ Diagnosis- Other _____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

Authorized Treatment Duration ☐ 12 Months ☐ Other _____

☑ **Pharmacy may round dose to nearest 50mg vial (dose adjustment not to exceed 10% deviation)**

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)
every 30 min, Resp, BP, HR, Temperature on admission to the unit and prior to infusion HR, BP and prior to discharge

Pre- Treatment Medications

Acetaminophen (Month 1 to 12)

☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before golimumab dose

Diphenhydramine (Month 1 to 12)

☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before golimumab dose

☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before golimumab dose

Methylprednisolone (Month 1 to 12)

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before golimumab dose

☐ *125 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before golimumab dose

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____

Simponi Aria® (golimumab) Treatment Plan (Rheumatology)

Loading Dose Simponi (golimumab) (week 0,4)

☐ Simponi Aria infused at week 0 and week 4
2 mg/kg, IV Piggyback, Injection, Day of Tx
Comments: Dilute with 100 mL 0.9% NaCl. Infuse the diluted solution over 30 minutes with 0.22 micron in-line filter

---Followed by---

Maintenance dose Dose Simponi (golimumab) (week 0,4,8,16,24,32,40)

☑ Simponi Aria (Week 0, 8, 16, 24, 32, 40)
2 mg/kg, IV Piggyback, Injection, Day of Tx, every 8 weeks
Comments: Dilute with 100 mL 0.9% NaCl. Infuse the diluted solution over 30 minutes via 0.22 micron filter se

☑ Communication Order (Month 1 to 12)
Patient must stay in infusion area for 30 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician.

☑ Communication Order (Month 1 to 12)
Ensure negative PPD or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ Communication Order (Month 1 to 12)
Ensure negative Hepatitis B Surface Antigen or HBS Surface Antibody. Results must be within the last 12 months.

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, Pruritis, urticaria, persistent flushing Temperature > 100 or HR <50 or > 130

☑ Notify Provider (Month 1 to 12)
For POSITIVE results of PPD test or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ Notify Provider (Month 1 to 12)
For POSITIVE results of Hepatitis B surface antigen or if results are not available. Results must be within the last 12 months.

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Labs (Month 1 to 12) Duration: 12 Months

☑ Quantiferon(R)-TB Gold, 4T, Incu-(36971) (If Needed)
☑ Hepatitis B Surface Antibody, Qual-(499) (If Needed)
☑ Hepatitis B Surface Antigen w Ref/Conf-(498) (If Needed)
☑ Hepatitis B Core Antibody, Total-(501) (If Needed)
☑ CBC w/ Diff (If Needed)
☑ BMP (If Needed)
☑ Urinalysis with Microscopic, if indicated (If Needed)

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____