Simponi ARIA® golimumab for infusion

Horizon Infusions

Patient Status: ☐ NEW* ☐ CONTINUING

Next Due Date (if applicable) _____ Choose Location _

*Include recent labs and last 2 office visit notes

Name _____ DOB _____

Phone _____ Other Phone _____

Email _____ SSN _____

Allergies _____ Weight _____ ☐LBS ☐Kg Gender ☐M ☐F

INSURANCE INFORMATION (Required)

Submit copies of the front and back of primary and/or secondary insurance cards with this referral

Physician Name _____ NPI# _____

License # _____ TIN# _____ DEA# _____

Address _____

City _____ State _____ Zip _____

Office Contact _____ Email _____

Phone _____ Fax _____

DIAGNOSIS INFORMATION:

☐ **Rheumatoid Arthritis** _____ ☐ **Other:** _____

***REQUIRED:**
- **TB within last year and ANNUALLY**
- **HBV prior to starting; 1x occurrence unless HBV carrier**

DOSING

☐ **Initial** ☐ **Maintenance**

☐ **Initial Dose: Administer 2mg/kg IV over 30 minutes at week 0 and 4; then every 8 weeks thereafter**

☐ **Maintenance Dose: Administer _____mg at _____mg/kg IV every _____ week(s)**

☐ **Vital signs per HI Protocol**

☐ **Anaphylaxis & Hydration Management per HI Protocol**

PRE-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg

☐ Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)

☐ Diphenhydrimine (Benadryl) ☐ 25mg ☐ 50mg ☐ PO ☐ IV (requires driver)

☐ Methylprednisolone (Solu-Medrol) ☐ 40mg ☐ 80mg ☐ 125mg IV

☐ Prednisone _____ mg PO

☐ Other _____

POST-MEDICATIONS ☐ N/A

☐ Acetaminophen ☐ 500mg ☐ 650mg ☐ 1000mg

☐ Prednisone _____ mg PO

☐ Other _____

LABS

☐ CBC w/Diff	☐ Each Infusion	☐ Other Frequency (specify): _____
☐ CRP	☐ Each Infusion	☐ Other Frequency (specify): _____
☐ CMP	☐ Each Infusion	☐ Other Frequency (specify): _____
☐ ESR	☐ Each Infusion	☐ Other Frequency (specify): _____
☐ Hepatic Panel	☐ Each Infusion	☐ Other Frequency (specify): _____
☐ Renal Panel	☐ Each Infusion	☐ Other Frequency (specify): _____

☐ Quantiferon TB Gold, annually, last completed (date): _____

☐ Other (specify): _____

Provider Signature _____ Date _____

For new referrals, please include recent labs and last two office visit notes.

Fax Referrals to: Kentucky (888) 977-0914 | New York (315) 457-4305 | Ohio (888) 977-0914 | Pennsylvania (724) 240-1586