SPECIALTY INFUSION CENTER
An Access Infusion Care Company

GOLIMUMAB (IV)

CENTERS AT SIC
An Access Infusion Care Managed Company

REFERRAL CHECKLIST
Please ensure the following information is included with your referral:
☐ Patient Demographics and Contact Information
☐ Patient Insurance Information
☐ Completed H&P and Progress Notes Including Medications and Allergies
☐ Recent Lab Results/Testing/Screenings Supporting the Diagnosis
☐ TB and HepB screening results
☐ Completed and Signed Referral
Including this information will minimize delays with prior authorizations and ensure timely treatment for your patient. Thank you!

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Print, complete, and fax completed form to (855) 857-3834

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PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name:	Prescriber Name:
Address:	NPI:
City, State, Zip:	Address:
Cell: Email:	City, State, Zip:
Ht: Wt: kg Last 4 of SSN: DOB:	Phone: Fax:
Allergies:	Contact Person:

REFERRAL STATUS ☐ New Referral ☐ Continuation Order ☐ Dose or Frequency Change

First dose? ☐ Yes ☐ No - Date of last infusion:	Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS

☐ Dx Code/description:

REQUIRED DOCUMENTATION ☐ Signed order ☐ Demographics/insurance info ☐ H&P/labs/tests/progress notes supporting the Dx

Prior Therapies:

☐ Hepatitis B Screening: ☐ Positive ☐ Negative-Date:	☐ TB Screening: ☐ Positive ☐ Negative-Date:

PRESCRIBING INFORMATION

LAB ORDERS

Frequency: Every Labs: ☐ CMP ☐ CBCwdif ☐ CRP ☐ Sed Rate ☐ Other:

PREMEDICATIONS (administer 30 minutes prior to infusion)

Acetaminophen: ☐ 650mgPO ☐ 1000mgPO	Methylprednisolone: ☐ 100mgIV ☐ 125mgIV ☐ mgIV
Diphenhydramine: ☐ 25mgPO ☐ 50mgPO ☐ 25mgIV ☐ 50mgIV	Other: ☐

MEDICATION

Medication	Strength	Dose/Directions	Quantity
☐ **Golimumab** ☐ **Specific Product (optional):**	50mg/4mL	**IV - Induction** ☐ 2mg/kg at week 0, 4, then every 8 weeks thereafter ☐ mg at week 0, 4, then every 8 weeks thereafter **IV - Maintenance** ☐ 2mg/kg every 8 weeks ☐ mg every 8 weeks Infuse in 100ml 0.9%NS total volume IV over 30 minutes	☒ Vials sufficient for dose Refills:

If no product is specified, an insurance-preferred biosimilar may be used.
Use current documented weight; round calculated dose to nearest vial size +/- 10% of dose.
If not specified, order will be valid for 1 year from the date of signature.

NURSING INSTRUCTIONS/EMERGENCY MEDICATION

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines Post-Infusion:Use 50ml0.9%NS to flush residual priming volume	PIV:Flush 3-10mL0.9%NS before/after PICC/Midline/Port:Flush 10mL0.9%NS before/after, then 3mLHeparin 10u/mL(PICC/Midline)/ 5mLHeparin 100u/mL(Port) final

Administer the following medications as needed for infusion-related reactions per company protocol:
Adults>40kg: Diphenhydramine25-50mgPO or IVP(2-5min); Acetaminophen325-650mgPO; Methylprednisolone125mgIVP(≥5min); Epinephrine0.3mgIM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Pediatrics/Adults<40kg: Diphenhydramine25mgPO or IVP(2-5min); Acetaminophen325mgPO; Methylprednisolone40mgIVP(≥5min); Epinephrine0.15mg(<30kg)/0.3mg(>30kg)IM/SQ, may repeat×1; 0.9%NS500mL IV over 30-60min, may repeat×1 for hypotension.
Oxygen(AIC/AIS only):1-6L/min via NC/face mask; titrate to maintain SpO_2 95-100%.

Prescriber Signature X: _____ **Date:** _____

☐ **Product Substitution Permitted** ☐ **Dispense as Written**

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