



PATIENT INFORMATION (Complete or Fax Existing Chart)		PRESCRIBER INFORMATION	
Name: _____ DOB: _____ Address: _____ City, State, Zip: _____ Phone: _____ Alt. Phone: _____ Email: _____ SS#: _____ Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____ Allergies: _____		Prescriber Name: _____ State License: _____ NPI #: _____ Tax ID: _____ Address: _____ City, State, Zip: _____ Phone: _____ Fax: _____ Office Contact: _____ Phone: _____	
INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)			
Primary Insurance: _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____		Secondary Insurance (If Applicable): _____ Plan #: _____ Group #: _____ RX Card (PBM): _____ BIN: _____ PCN: _____	
CLINICAL INFORMATION			
<input type="checkbox"/> M05.79 Rheumatoid arthritis with rheumatoid factor without organ or systems involvement <input type="checkbox"/> M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified <input type="checkbox"/> L40.53 Psoriatic spondylitis <input type="checkbox"/> L40.54 Juvenile psoriatic arthritis			
<input type="checkbox"/> M05.70 Rheumatoid arthritis with rheumatoid factor, unspecified site, without organ or system involvement <input type="checkbox"/> L40.50 Arthropathic psoriasis, unspecified <input type="checkbox"/> M45.0 Ankylosing spondylitis of multiple sites in spine <input type="checkbox"/> Other ICD-10/Diagnosis: _____			
Date of negative TB test: _____ <input type="checkbox"/> TB test pending, will fax results Patient is HBV negative or has been treated: <input type="checkbox"/> Yes <input type="checkbox"/> No History of kidney disease: <input type="checkbox"/> Yes <input type="checkbox"/> No GFR/CrCl: _____ History of heart failure <input type="checkbox"/> Yes <input type="checkbox"/> No **Obtain the following labs at prior to start of treatment and at _____ frequency: <input type="checkbox"/> CBC <input type="checkbox"/> CMP <input type="checkbox"/> CRP <input type="checkbox"/> ESR <input type="checkbox"/> LFTs <input type="checkbox"/> X-Ray <input type="checkbox"/> Other: _____			
SIMPONI ARIA® ORDERS			
Prescription type: <input type="checkbox"/> New start <input type="checkbox"/> Restart <input type="checkbox"/> Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____			
Medication	Dose/Strength	Directions	Refills
Simponi Aria® (golimumab)	<input type="checkbox"/> 50mg/4ml Vial <input type="checkbox"/> Other: _____	Starting Dose: <input type="checkbox"/> Infuse 2mg/kg IV at week 0 and 4 <input type="checkbox"/> Other: _____ Maintenance Dose: <input type="checkbox"/> Infuse 2mg/kg every 8 weeks <input type="checkbox"/> Other: _____	Refills: _____
Pre- Medication		Route	Dose
<input type="checkbox"/> Acetaminophen		<input type="checkbox"/> By mouth	<input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg
<input type="checkbox"/> Methylprednisolone (Solu-Medrol)		<input type="checkbox"/> IV	<input type="checkbox"/> 60mg <input type="checkbox"/> 100 mg <input type="checkbox"/> _____mg
<input type="checkbox"/> Diphenhydramine (Benadryl)		<input type="checkbox"/> IV <input type="checkbox"/> By mouth	<input type="checkbox"/> 25mg <input type="checkbox"/> 50mg
Other: _____		_____	_____

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ANAPHYLACTIC REACTION (AR):

- ☐ EpiPen® Auto-injector 0.3 mg (1:1000) Inject IM -or- SubQ to patients who weigh ≥ 66 lbs (≥ 30 kg); may repeat in 3-5 mins x 1 if necessary
- ☐ EpiPen Jr® Auto-injector 0.15mg (1:2000) Inject IM -or- SubQ to patients who weigh 33 - 66 lbs (15-30 kg): may repeat in 3-5 mins x 1 if necessary
- ☐ Diphenhydramine 50mg (1mL) - Administer 50 mg VIA slow IVP, administer IM if no IV access; may repeat x 1 after 10 mins, if necessary
- ☐ Methylprednisolone 40mg - administer 40 mg IVP -or- IM if no IV access
- ☐ Sodium Chloride 0.9% 500 mL infuse IV at a rate of up to 999 mL/hr
- ☐ Other: _____

SIGNATURE

We hereby authorize Valustar to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X _____

Prescriber Signature

Date: _____

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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