SIMPONI ARIA®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____

Address: _____

City, State, Zip: _____

Phone: _____ Alt. Phone: _____

Email: _____ SS#: _____

Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____

Allergies: _____

PRESCRIBER INFORMATION

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

☐ M05.79 Rheumatoid arthritis with rheumatoid factor without organ or systems involvement

☐ M05.70 Rheumatoid arthritis with rheumatoid factor, unspecified site, without organ or system involvement

☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified

☐ L40.50 Arthropathic psoriasis, unspecified

☐ L40.53 Psoriatic spondylitis

☐ M45.0 Ankylosing spondylitis of multiple sites in spine

☐ L40.54 Juvenile psoriatic arthritis

☐ Other ICD-10/Diagnosis: _____

Date of negative TB test: _____ ☐ TB test pending, will fax results Patient is HBV negative or has been treated: ☐ Yes ☐ No

History of kidney disease: ☐ Yes ☐ No GFR/CrCl: _____ History of heart failure ☐ Yes ☐ No

**Obtain the following labs at prior to start of treatment and at _____ frequency: ☐ CBC ☐ CMP ☐ CRP ☐ ESR ☐ LFTs ☐ X-Ray ☐ Other: _____

SIMPONI ARIA® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Strength	Directions	Refills
Simponi Aria® (golimumab)	☐ 50mg/4ml Vial ☐ Other:_____	**Starting Dose:** ☐ Infuse 2mg/kg IV at week 0 and 4 ☐ Other: _____ **Maintenance Dose:** ☐ Infuse 2mg/kg every 8 weeks ☐ Other: _____	Refills: _____

Pre- Medication	Route	Dose
☐ Acetaminophen	☐ By mouth	☐ 500mg ☐ 650mg ☐ 1000mg
☐ Methylprednisolone (Solu-Medrol)	☐ IV	☐ 60mg ☐ 100 mg ☐ _____mg
☐ Diphenhydramine (Benadryl)	☐ IV ☐ By mouth	☐ 25mg ☐ 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_____ Date: _____

Prescriber Signature

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.