Simponi Aria (Golimumab)

☐ **New Referral** ☐ **Continuing Treatment** ☐ **Medication Order Change**

Patient Information:

Name:______________________________
Date:______________________________
DOB:______________________________
SS#:______________________________
Phone #:______________________________
Email:______________________________

Physician Information:

Referring Physician: ______________________________

Address:______________________________
____

Phone #:______________________________

Fax #:______________________________

Medication Orders

Patient Weight: _______kg Patient Height: _________inches ☐ First Dose ☐ Maintenance Dose

Dosing: ☐ **LOADING DOSES: 2 MG/KG IV @ 0 weeks, 4 weeks, and then every 8 weeks**

☐ **MAINTENANCE DOSE: 2 MG/KG IV every 8 weeks**

Premeds(if applicable): ☐ ____________ ☐ ____________ ☐ ____________ ☐ ______________

Indication / Diagnosis:

- ☐ M05.____ Rheumatoid arthritis
- ☐ M06.____ Rheumatoid arthritis, unspecified
- ☐ L40._____ Psoriatic arthritis
- ☐ M45.____ Ankylosing spondylitis
- ☐ Other (please specify)____________________

ICD-10 (Required) ____

MD Signature: ________________________NPI#:________________________ Date: ___________

Required Documentation

Please send the following documents and records. This will help streamline the pre-authorization process.

- **If this is a continuation of a treatment, include the last infusion note**
- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- Current medication list

<u>Most recent diagnostics results to include:</u>

- CMP/BMP
- CBC with differential
- TB test: QGT, TSpot (within 2 years) - if HX of TB or + QGT, need negative Chest Xray report sent
- Hepatitis C-Ab
- Hepatitis B-Core Ab, B SAg, B SAb

We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.

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