TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

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

☐ 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

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: __________

SIGNATURE

We hereby authorize Talis Healthcare LLC 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.

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