Simponi Aria (golimumab) Referral Form

RETURN COMPLETED FORM
VIA FAX TO:
888.898.9113

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ______________________	Prescriber Name: ______________________
Address: ______________________	NPI #: ____________ DEA: ____________
City, State, Zip: ______________________	Phone: ______________________
Phone: ____________ Alt Phone: ____________	Address: ____________ Fax: ____________
DOB: ________ Gender: ☐ M ☐ F	City, State, Zip: ______________________
	Contact Person: ____________ Phone: ________

INSURANCE INFORMATION - OR - Send a copy of the patient's prescription / insurance cards (front & back)

Primary Insurance ______________________	RX Card (PBM): ______________________
City, State, Zip ______________________	BIN: ____________ PCN: ____________
Member ID #: ____________ Phone: ____________	City, State, Zip: ______________________
Plan #: ____________ Group #: ____________	Plan #: ____________ Group #: ____________

DIAGNOSIS / CLINICAL INFORMATION – MEDICATION ORDERS

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

☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified

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

☐ L40.50 Arthropathic psoriasis, unspecified

☐ **Other – ICD-10:____________________ Specify:**

Patient Weight:__________lbs.	☐ Initial / Reload Dosing:________mg/kg IV on day 0, 4 weeks, then every_______weeks.
	☐ Maintenance Dosing:________mg/kg IV every________weeks.

DOCUMENTATION REQUIRED

☐ Current Office Notes, including therapies tried and outcomes
☐ Current Medication List
☐ History and Physical Report
☐ Lab Results
☐ Insurance Card Information (front and back)
☐ Demographic Sheet

NEW PATIENT REFERRALS MUST INCLUDE LAB RESULTS

☐ HepB Surf Ag (within 12 months)
☐ HepB Core Ab (within 12 months)
☐ PPD Results (within 12 months)
☐ Chest X-ray (if indicated)
☐ Comprehensive Metabolic Panel, CBC with differential (within past 3 months)

PHYSICIAN'S SIGNATURE

X______________________________________ Date: ____________________

Important Information: This facsimile transmission is intended to be delivered only to the named addressee and may contain material that is confidential, privileged, proprietary or exempt from disclosure under applicable law. If it is received by anyone other than the named addressee, the recipient should immediately notify the sender at the address and telephone number set forth herein and obtain instructions as to disposal of the material. In no event should such material be read by anyone other than the named addressee, except by express authority of the sender to the named addressee.