



PATIENT INFORMATION (Complete or Fax Existing Chart)	PRESCRIBER INFORMATION
Name: _____ DOB: _____	Prescriber Name: _____
Address: _____	State License: _____
City, State, Zip: _____	NPI #: _____ Tax ID: _____
Phone: _____ Alt. Phone: _____	Address: _____
Email: _____ SS#: _____	City, State, Zip: _____
Gender: <input type="checkbox"/> M <input type="checkbox"/> F Weight: _____ (lbs) Ht: _____	Phone: _____ Fax: _____
Allergies: _____	Office Contact: _____ Phone: _____

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

Primary Insurance: _____	Secondary Insurance (If Applicable): _____
Plan #: _____	Plan #: _____
Group #: _____	Group #: _____
RX Card (PBM): _____	RX Card (PBM): _____
BIN: _____ PCN: _____	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)	<input type="checkbox"/> 50mg/4ml Vial <input type="checkbox"/> Other: _____	<b>Starting Dose:</b> <input type="checkbox"/> Infuse 2mg/kg IV at week 0 and 4 <input type="checkbox"/> Other: _____ <b>Maintenance Dose:</b> <input type="checkbox"/> Infuse 2mg/kg every 8 weeks <input type="checkbox"/> 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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