

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____
Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Rheumatoid Arthritis with Rheumatoid factor ICD-10 Code: M05. _____
 _____ Rheumatoid Arthritis without Rheumatoid factor ICD-10 Code: M06. _____
 _____ Psoriatic Arthritis ICD-10 Code: L40.5 _____
 _____ Ankylosing Spondylitis ICD-10 Code: M45. _____
 _____ Other: _____ ICD-10 Code: _____

Allergies: _____ (or attach list)

Patient
Weight: _____ lbs.
Height: _____ in.

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
 - TB Screening Results
 - Hepatitis B Screening (including Hep B surface antigen & Hep B Core Antibody)
- Previous Drug Therapy History, including therapies trailed/failed and date of last administration:

Agent: _____ Date: _____ Desired Washout Period: _____ weeks

SIMPONI ARIA® (golimumab) J Code: J1602

4. Drug Order:

- New Start:** Administer Simponi ARIA _____ mg (2 mg/kg) IV over 30 minutes on 0, 4 and 8 weeks.
- On-going Maintenance:** Administer Simponi ARIA _____ mg (2 mg/kg) IV over 30 minutes.
 _____ #Refills (Recommend 4)

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX 803.999.1754 ALTERNATE FAX 803.999.1887	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 800.767.6337
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