INTRAMED Plus
infusion services

SIMPONI ARIA®

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® (goliumumab) 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	INFUSION CENTER LOCATIONS
CENTRAL FAX **803.999.1754**	COLUMBIA CHARLESTON GREENVILLE
ALTERNATE FAX 803.999.1887	CENTRAL INTAKE PHONE 803.999.1960