Simponi Aria®

Provider Order Form Rev. 07/2023

Please fax completed referral form & all required documents to (833) 786-0025

HEALIX INFUSION CARE

PATIENT DEMOGRAPHICS

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City/ST/Zip: _____

Allergies: _____ ☐ NKDA Weight: _____ ☐ lbs ☐ kg Height: _____ ☐ in ☐ cm

Patient Status: ☐ New to Therapy ☐ Dose or Frequency Change ☐ Order Renewal

INSURANCE INFORMATION: ***Please attach copy of insurance card (front and back).***

DIAGNOSIS*

ICD 10 Code Required

☐ Rheumatoid Arthritis (M05.70-M05.9, M06.00-M06.09, M06.9), ICD10 _____

☐ Psoriatic Arthritis (L40.50.-L40.59), ICD10 _____

☐ Ankylosing Spondylitis (M45.0-M45.9), ICD10 _____

☐ Other: _____, ICD10 _____

INFUSION ORDERS

MEDICATION	DOSE	DIRECTIONS/DURATION
Simponi Aria® (golimumab)	_____ mg (2 mg/kg)	☐ **INITIAL:** Infuse IV over 30 minutes at Weeks 0, 4, then every 8 weeks x 1 year ☐ **MAINTENANCE:** Infuse IV over 30 minutes every 8 weeks x 1 year

Is patient currently receiving therapy above from another facility?

☐ Yes ☐ No

If yes, Facility Name: _____

Date of last treatment:_____ Date of next treatment:_____

PRE-MEDICATION ORDERS

☐ No premeds ordered at this time

☐ Acetaminophen 650mg PO ☐ Diphenhydramine 25mg PO

☐ Methylprednisolone 40mg IVP -OR- ☐ Hydrocortisone 100mg IVP

☐ Other: _____

LAB ORDERS

Labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

☐ No labs ordered at this time

☐ CBC q _____ ☐ CMP q _____ ☐ CRP q _____

☐ ESR q _____ ☐ LFTs q _____ ☐ Other: _____

REFERRING PHYSICIAN INFORMATION

Physician Signature: _____ Date: _____

Physician Name: _____ Provider NPI:_____ Specialty:_____

Address: _____ City/ST/Zip: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Email Where Follow Up Documentation Should Be Sent: _____

REQUIRED CLINICAL DOCUMENTATION

Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.

LAB AND TEST RESULTS (required)

- TB screening (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by**:** ☐ Infusion Center ☐ Referring Physician
- Hepatitis B Screening (submit results to start therapy)

PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____

Medication Failed: _____ Dates of Treatment: _____ Reason for D/C: _____