SIMPONI ARIA® Infusion

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

_____ Rheumatoid Arthritis with Rheumatoid factor
_____ Rheumatoid Arthritis without Rheumatoid factor
_____ Psoriatic Arthritis
_____ Ankylosing Spondylitis
_____ Other: _____

Please attach the following: 1. List of current Medications, Previous Drug Therapy History, including therapies trailed/failed and date of last administration: Agent: _____ Date: _____ Desired Washout Period: _____ weeks 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs including TB Screening Results and Hepatitis B Screening (including Hep B surface antigen & Hep B Core Antibody)

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **SIMPONI ARIA® (goliumumab)**

_____ # Refills (Recommend 4)

☐ ***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.

☐ ***Other:*** _____

Pre-Medication Orders: No Pre-medications are recommended based on manufacturer guidelines.

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

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date