AYSA
THERAPEUTICS INFUSION

SIMPONI ARIA (GOLIMUMAB) ORDER FORM

P: 470.395.6076 | F: 470.745.0716

PATIENT INFORMATION

☐ *Demographics attached*

Patient Name: _____ DOB: _____ Phone: _____

INSURANCE INFORMATION: PLEASE ATTACH COPY OF PRESCRIPTION/MEDICAL CARD(S) (FRONT AND BACK)

MEDICAL INFORMATION

Diagnosis: ☐ Rheumatoid Arthritis (ICD-10: _____) ☐ Psoriatic Arthritis (ICD-10: _____)

☐ Ankylosing Spondylitis (ICD-10: _____)

☐ Other: _____ ICD-10: _____)

Patient Weight: _____ lbs.

Allergies: _____

☐ Clinical/Progress Notes, Labs, and Tests supporting primary diagnosis attached

☐ TB and Hepatitis B documentation attached

Hepatitis B Protocol: Hep B surface antigen and Hep B Core AB total required.

TB Protocol: Baseline testing: Quantiferon Gold (QFT Gold) or PPD. ☐ Yearly TB Screening *(optional)*

Labs: Required labs to be drawn by: ☐ Infusion Clinic ☐ Referring Physician

Lab Orders: _____

SIMPONI ARIA ORDERS

Intial dose: ☐ 2mg/kg at weeks 0, 4 and then every 8 weeks

Maintenance dose: ☐ 2mg/kg every 8 weeks

* Date of last ☐ Remicade ☐ Orencia ☐ Humira ☐ Cimzia ☐ Enbrel

☐ Actemra ☐ Kineret ☐ Simponi ARIA Dose: _____

ADDITIONAL ORDERS/COMMENTS

PHYSICIAN INFORMATION

By signing this form and utilizing our services, you are authorizing *At Your Service Anesthesia, Inc.*, and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies.

Physician Signature: _____ Physician Name: _____ Date: _____

Phone: _____ Fax: _____ Contact Person: _____