



**AYSAs**

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

Initial 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: \_\_\_\_\_

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