PARAGON INFUSION CENTERS

SIMPONI ARIA (GOLIMUMAB) INFUSION ORDERS

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, 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 Paragon Healthcare, 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: _____ Date: _____

Physician Name: _____

Phone: _____ Fax: _____ Contact Person: _____

INFUSION CENTER LOCATIONS

Phone: 877-365-5566 **Fax: 855-889-2946**	**Texas** ☐ Arlington ☐ Austin ☐ Dallas ☐ Houston ☐ North Hills ☐ Plano ☐ Round Rock ☐ San Antonio ☐ Stone Oak	**Tennessee** ☐ Knoxville	**Georgia** ☐ Atlanta

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