Simponi Aria (Golimumab) Referral Form

Phone: (877) 246-9104
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WWW.Biotekrx.com

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: ____________________	Prescriber Name: ____________________
Address: ____________________	NPI #: ____________ DEA: ____________
City, State, Zip: ____________________	Address: ____________________
Phone: ____________ 2nd Phone: ____________	Phone: ____________ Fax: ____________
DOB: ____________ Gender: ☐ Male ☐ Female	Contact Person: ____________ Phone: ____________

INSURANCE INFORMATION - OR - Send a copy of the patient's prescription / insurance cards (front & back)

Primary Insurance: ____________________	RX Card (PBM): ____________________
City, State, Zip: ____________________	BIN: ____________ PCN: ____________
Member ID #: ____________ Phone: ____________	City, State, Zip: ____________________
Plan #: ____________ Group #: ____________	Plan #: ____________ Group #: ____________

DIAGNOSIS / CLINICAL INFORMATION – MEDICATION ORDERS

☐ M05.79 Rheumatoid arthritis with rheumatoid factor without organ or systems involvement

☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified

☐ M05.70 Rheumatoid arthritis with rheumatoid factor, unspecified site, without organ or system involvement

☐ L40.50 Arthropathic psoriasis, unspecified

☐ **Other – ICD-10:** ____________ **Specify:**

Patient Weight: ________ lbs.	☐ Initial / Reload Dosing: _______ mg/kg IV on day 0, 4 weeks, then every ______ weeks.
	☐ Maintenance Dosing: _______ mg/kg IV every _______ weeks.

DOCUMENTATION REQUIRED

☐ Current Office Notes, including therapies tried and outcomes
☐ Current Medication List
☐ History and Physical Report
☐ Lab Results
☐ Insurance Card Information (front and back)
☐ Demographic Sheet

NEW PATIENT REFERRALS MUST INCLUDE LAB RESULTS

☐ HepB Surf Ag (within 12 months)
☐ HepB Core Ab (within 12 months)
☐ PPD Results (within 12 months)
☐ Chest X-ray (if indicated)
☐ Comprehensive Metabolic Panel, CBC with differential (within past 3 months)

PHYSICIAN'S SIGNATURE

X ______________________________ Date: ____________________

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