



Simponi Aria (Golimumab) Referral Form

Phone: (877) 246-9104

Fax: (800) 783-9146

WWW.Biotekrx.com

PATIENT INFORMATION	PRESCRIBER INFORMATION
Patient Name: _____	Prescriber Name: _____
Address: _____	NPI #: _____ DEA: _____
City, State, Zip: _____	Address: _____
Phone: _____ 2 nd Phone: _____	Phone: _____ Fax: _____
DOB: _____ Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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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