



**Birmingham, AL**  
F: 205-271-9971

**Huntsville, AL**  
F: 256-417-6408

**Knoxville, TN**  
F: 865-934-0249

**Nashville, TN**  
F: 615-645-4791

**Chantilly, VA**  
F: 703-935-2061

**PREVIOUS ADMINISTRATION**

**Please provide the following information:** Last Infusion Date: \_\_\_\_\_ Next Infusion Date: \_\_\_\_\_

**Patient Information**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M F Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Email Address: \_\_\_\_\_  
 Allergies: \_\_\_\_\_ Is the patient Diabetic: Y N ICD-10 Code: \_\_\_\_\_  
 Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**Primary Diagnosis:** \_\_\_\_\_ Rheumatoid Arthritis with Rheumatoid factor \_\_\_\_\_ Rheumatoid Arthritis without Rheumatoid factor  
 \_\_\_\_\_ Psoriatic Arthritis \_\_\_\_\_ Ankylosing Spondylitis  
 \_\_\_\_\_ Other: \_\_\_\_\_

**Please attach the following:** 1. List of current Medications, Previous Drug Therapy History, including therapies trailed/failed and date of last administration: Agent: \_\_\_\_\_ Date: \_\_\_\_\_ Desired Washout Period: \_\_\_\_\_ weeks 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs including TB Screening Results and Hepatitis B Screening (including Hep B surface antigen & Hep B Core Antibody)

**Physician Information**

Prescribing Physician: \_\_\_\_\_ Practice Name: \_\_\_\_\_  
 Practice Phone: \_\_\_\_\_ Practice Fax: \_\_\_\_\_  
 Email: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
 Co-managing Physician: \_\_\_\_\_ Phone/Email: \_\_\_\_\_

**Medication Order**

**Medication:** SIMPONI ARIA® (golimumab)

\_\_\_\_\_ # Refills (Recommend 4)

**New Start:** Administer Simponi ARIA \_\_\_\_\_ mg (2 mg/kg) IV over 30 minutes on 0, 4 and 8 weeks.

**On-going Maintenance:** Administer Simponi ARIA \_\_\_\_\_ mg (2 mg/kg) IV over 30 minutes.

**Other:** \_\_\_\_\_

**Pre-Medication Orders:** No Pre-medications are recommended based on manufacturer guidelines.

**Adverse Drug Reaction Protocol:** Manage any adverse reaction that may occur per approved ADR Protocol.

**By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

\_\_\_\_\_  
Physician's NPI#

\_\_\_\_\_  
Physician's Address

\_\_\_\_\_  
Prescriber's Signature

\_\_\_\_\_  
Date