TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

SIMPONI ARIA®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: _____ DOB: _____
Address: _____
City, State, Zip: _____
Phone: _____ Alt. Phone: _____
Email: _____ SS#: _____
Gender: ☐ M ☐ F Weight: _____(lbs) Ht: _____
Allergies: _____

PRESCRIBER INFORMATION

Prescriber Name: _____
State License: _____
NPI #: _____ Tax ID: _____
Address: _____
City, State, Zip: _____
Phone: _____ Fax: _____
Office Contact: _____ Phone: _____

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

Primary Insurance: _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

Secondary Insurance (If Applicable): _____
Plan #: _____
Group #: _____
RX Card (PBM): _____
BIN: _____ PCN: _____

CLINICAL INFORMATION

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

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

☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified

☐ L40.50 Arthropathic psoriasis, unspecified

☐ Other ICD-10/Diagnosis: _____

Date of negative TB test: _____ ☐ TB test pending, will fax results Patient is HBV negative or has been treated: ☐ Yes ☐ No

History of kidney disease: ☐ Yes ☐ No GFR/CrCl: _____ History of heart failure ☐ Yes ☐ No

SIMPONI ARIA® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: _____ Date of Last Injection/Infusion: _____

Medication	Dose/Strength	Directions	Refills
Simponi Aria® (golimumab)	☐ 50mg/4ml Vial ☐ Other:_____	**Starting Dose:** ☐ Infuse 2mg/kg IV at week 0 and 4 ☐ Other: _____ **Maintenance Dose:** ☐ Infuse 2mg/kg every 8 weeks ☐ Other: _____	Refills: _____

SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X_____ Date: _____

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.