SIMPONI ARIA® Infusion

OptiMed
Phone: 877.385.0535
Fax: 877.326.2856
6480 Technology Ave., Suite A | Kalamazoo, MI 49009

Please complete each section of the referral form below and fax to OptiMed along with a copy (front and back) of all the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Information

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

Patient Information

Name: _____ **DOB:** _____ ☐M ☐F

Address: _____

Phone: _____ **2nd Phone:** _____ **SSN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (include ICD-10 code): _____

Weight: _____ ☐lb ☐kg **Height:**_____ ☐in **IV access:** ☐PIV ☐PICC ☐Port ☐Other: _____

Patient's first dose of SIMPONI ARIA? ☐Yes ☐No, date of last dose _____ ; prior dose (in mg): _____

Allergies: _____ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: _____

_____

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

History of kidney disease: ☐Yes ☐No If yes, SCr: _____ GFR/CrCl: _____ **History of heart failure:** ☐Yes ☐No

Referring provider's preferred site of care*: ☐OptiMed Infusion Center ☐Home Infusion* ☐OptiMed to determine site of care
*Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.

Additional Notes: _____

_____

Prescription Information

SIMPONI ARIA® dose: ☐2 mg/kg ☐Other: _____mg in 100mL NaCl 0.9% infused IV over 30 minutes.

Based on the clinical judgement of the pharmacist, doses may be rounded up or down by no more than 10% unless checked here: ☐

Supply Items: Infuse through an infusion set containing a sterile, non-pyrogenic, low-protein-binding filter with pore size of 0.22µm or less.

Dosing Regimen	Quantity
☐ **Induction:** Infuse at weeks 0 and 4.	2 doses (infusions)
☐ **Maintenance:** Beginning week 12, infuse every 8 weeks.	_____ doses (infusions)

Premedication orders: _____

PRN medication orders: _____

Laboratory orders (subject to availability): _____

_____

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize OptiMed and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____

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CLEAR FORM