SIMPONI ARIA (golimumab) Referral Order Form

FAX (877) 637-6691

VASCO INFUSION

WWW.VASCOINFUSION.COM

PH: 602-346-0204 FAX: 877-637-6691

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)*

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners. _____

PATIENT INFORMATION

Name: _____

DOB: _____ SS#: _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

Office Contact: _____

Contact Phone #: _____ Contact Fax #: _____

NPI / TIN: _____ _____

SIMPONI ARIA MEDICATION ORDERS

Patient Weight: _____ kg

☐ Initial/Reload Dosing: _____ mg/kg IV on day 0, 4 weeks, then every _____ weeks.

☐ Maintenance Dosing: _____ mg/kg IV every _____ weeks.

INDICATION/DIAGNOSIS

- ☐ 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 *(please specify in notes)*

***ICD-10 required**

NOTES (ADDITIONAL INFO)

_____ _____

Referring Physician's Signature Date

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ HepB Surf Ag (w/in 12 months) ☐ HepB Core Ab (w/in 12 months) ☐ PPD Results (w/in 12 months)

☐ Chest X-ray (if indicated) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY