Fax Referrals To: (855) 891-2191
Email Referrals To: referrals@vivoinfusion.comHave a Question? (855) 478-1528

SIMPONI ARIA® (GOLIMUMAB) ORDER FORM
(- Required Fields)*

STAT REQUEST
(*REASON MUST BE PROVIDED BELOW)

New Referral **Referral Renewal** **Medication/Treatment Change**
Benefits Verification Only **Discontinuation Order**

PATIENT INFORMATION

NAME*:		DOB*:	SEX: ☐M ☐F
ADDRESS:		PHONE:	
WEIGHT: LBS ☐KG	HEIGHT:	EMAIL:	
ALLERGIES:			

PHYSICIAN INFORMATION

PHYSICIAN NAME*:		PRACTICE NAME:
ADDRESS:		OFFICE CONTACT*:
PHONE:	FAX:	EMAIL *(FOR UPDATES)*:

SIMPONI ARIA Infusion*:
*(SELECT **ONE** OF THE FOLLOWING)*

ICD-10*: ______________________________

Initial/Reload Dosing then Maintenance Dosing:
2 mg/kg IV on day 0, 4 weeks, then every 8 weeks

Maintenance Dosing: 2 mg/kg IV every 8 weeks

Physician Signature* ______________________________ **Date*(Referral Valid for One Year)**______________________

***NPI #**______________________
Infusion will be administered per MPP policy and protocols

ICD-10 Description:

***STAT REASON:**
(STAT requests will be assessed per MPP policy and protocols)

Last Infusion/Injection Date: ______________________

REQUIRED DOCUMENTATION CHECKLIST:

- Patient Demographics
- Insurance Card/Information
- Progress Notes supporting DX
- Current Medication List and H&P
- Complete Metabolic Panel
- Hep B Core (if available)
- Hep B Surface Antigen (*within 36 months*)
- TB Results (w/in 6 months)- *if positive, need negative chest x-ray and negative T Spot*

STANDING LAB REQUEST (to be drawn by clinic): CMP CBC *Frequency ______________________

Additional comments/notes:

Locations:

--------Colorado-------
Lakewood

--------Florida---------
Jacksonville
Kissimmee
Port St. Lucie
Suncoast
Winter Park

---------Ohio---------
Beachwood
Middleburg Hts.
Painesville
Youngstown
Westlake
Fairlawn

-------Oklahoma-------
Tulsa

---------Texas---------
Arlington
Cedar Hill
Dallas
Denton
Ft. Worth
Irving
Rockwall
Southlake
Flower Mound
Plano
Tyler

REVISION DATE- 5/2022