Simponi Aria

INFUSION FOR HEALTH
InfusionForHealth.com
Ph: 888-777-1945 | Fax: 805-852-2636

Date: _____ Treatment Location: _____

PROVIDERS: Please include the following to expedite the order. Demographics and insurance. Relevant, recent office notes. Current medication list. TB Labs. Hep B results
If applicable, please list tried and failed medications for the indicated disease.

PATIENT INFORMATION

Patient Name: _____

Patient Contact Number: _____

DOB: _____

Allergies: _____

Weight: _____ lbs / kg Height: _____

Diagnosis:
- ☐ M06.9 Rheumatoid Arthritis, unspecified
- ☐ L40.53 Psoriatic Arthritis
- ☐ M45.9 Ankylosing Spondylitis
- ☐ M08.3 pJIA

Other Dx/ICD10: _____

PRESCRIBER INFORMATION

Prescriber's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

Contact Email: _____

PREMEDS

☐ No Premeds **Center will use Hypersensitivity protocol established by Infusion for Health and P.I.**

SAPHNELO DOSAGE

Date of Last Treatment, If Continuation: _____

Route: ☑ IV

Total Dose: _____ mg (2 mg / kg)

Start Date: _____

Adult: ☐ 2mg/kg
Administer at 0, 4 weeks, **then** Q 8 weeks.

Pediatric: ☐ 80mg/m^2
Administer at 0, 4 weeks, **then** Q 8 weeks.

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, Infusion for Health is authorized to administer generic or biosimilar.

Lab Orders: ☐ List: _____

☐ Prior to first appointment ☐ Other Frequency: _____

☐ Please check this box if you **DO NOT** authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

☐ Please check this box if you **DO NOT** authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.