

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.**

SIMPONI ARIA 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/m²

Administer at 0, 4 weeks, **then** Q 8 weeks.

To ensure that a brand name product be dispensed, the prescriber must handwritten "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.