Simponi Aria

INFUSION FOR HEALTH

Treatment Location: ____________

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, TB Test, Hep B Test

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ☐ M06.9 ☐ L40.53 ☐ M45.9 ☐ M08.3 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING

☑ Center will use Hypersensitivity protocol established by Infusion for Health and PI

☑ TB Status and Date (list results & attached clinicals): ____________

☑ Hepatitis B Status and Date (list results & attach clinicals): ____________

PRE-MEDICATION ORDERS

Pre-medications not usually indicated

☐ Diphenhydramine ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ Acetaminophen ☐ 325mg / ☐ 500mg / ☐ 650mg PO

☐ Other: ____________

Dose: ______ Route: ______ Frequency: ______

SPECIAL INSTRUCTIONS:

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every ______

☐ CMP ☐ at each dose ☐ every ______

☐ 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.

THERAPY ADMINISTRATION

☑ Simponi Aria Intravenous Infusion

Dose: ☐ 2mg/kg or ☐ Total Dose: ______mg

Frequency:

☐ Induction: Week 0, 4, then

☐ Maintenance: Every 8 weeks

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ ______

(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print)	Provider Signature	Date

☐ ***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.***