

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____
 Address: _____ Phone: _____ Allergies: _____
 City, State, Zip: _____ Email: _____

REFERRAL STATUS

New Referral Dose or Frequency Change Order Renewal

Is this the first dose? Yes No, date of last infusion: _____ Line type: PIV PICC Port Other

DIAGNOSIS AND ICD-10 CODE

<input type="checkbox"/> Moderate to Severe Rheumatoid Arthritis (RA)	ICD-10 Code: _____
<input type="checkbox"/> Psoriatic Arthritis (PsA)	ICD-10 Code: _____
<input type="checkbox"/> Ankylosing Spondylitis (AS)	ICD-10 Code: _____
<input type="checkbox"/> Polyarticular Juvenile Idiopathic Arthritis (pJIA)	ICD-10 Code: _____
<input type="checkbox"/> Other Diagnosis: _____	ICD-10 Code: _____

REQUIRED DOCUMENTATION

<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress notes supporting primary diagnosis
<input type="checkbox"/> Patient demographics AND insurance information	<input type="checkbox"/> Labs and Tests supporting primary diagnosis
<input type="checkbox"/> TB Test Results	<input type="checkbox"/> Hepatitis B Test Results: HBsAg & Total HepB Core Antibody

List Tried & Failed Therapies, including duration of treatment:

- 1)
- 2)
- 3)

MEDICATION ORDERS

Initial Dosing	<input type="checkbox"/> Simponi Aria _____mg IV over 30 minutes at Week 0, 4, then every 8 weeks thereafter
Maintenance Dosing	<input type="checkbox"/> Simponi Aria 2 mg/kg IV over 30 minutes at Week 0, 4 then every 8 weeks thereafter
	<input type="checkbox"/> Simponi Aria 2 mg/kg IV over 30 minutes every 8 weeks
	<input type="checkbox"/> Simponi Aria _____ mg IV over 30 minutes every _____ weeks

Refills*: X 6 months X 1 Year Other: _____

*(if not indicated, order will expire 1 year from date signed)

RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration
 RN to flush and lock VAD/CVAD per company protocol

Other: _____

PREMEDICATION ORDERS

<input type="checkbox"/> Acetaminophen 650mg PO prior to infusion	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Diphenhydramine 25mg PO prior to infusion	<input type="checkbox"/> Other: _____

EMERGENCY MEDICATIONS

Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
 Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
 Acetaminophen 325mg-650mg PO
 Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.3mg IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
 Diphenhydramine 25mg slow IV push over 2-5 mins
 Acetaminophen 325mg PO
 Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
 Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
 Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____
 Office Phone: _____ Office Fax: _____
 Prescriber Signature: _____ Date: _____