Intravene - Simponi ARIA Infusion Orders (rev 10/2018)

Please fax this form along with a copy of insurance cards to:
Fax (434) 455-5531 or Call (434) 947-3900 ext. 2172

PATIENT INFORMATION

Name ______________________________
Address ____________________________
City ______________________________
State ______________ Zip code _________
Home Phone # _______________________
Work Phone # _______________________
DOB _________SSN ________Sex______
Height ___________ Weight ___________
Allergies ___________________________
Primary Insurance ____________________
Secondary Insurance __________________

REFERRING PHYSICIAN INFORMATION

Physician Name ______________________
Physician Address_____________________
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Physician Phone ______________________
Physician Fax ________________________
NPI# ____________ DEA # _________
State License#_______________________

** ***Please fax copy of insurance cards**
Current office visit notes if available
and this form to (434)- 455-5531***

DIAGNOSIS:ICD-10 (required)

- ☐ ______________________________ ______________________________
- ☐ ______________________________ ______________________________
- ☐ ______________________________ ______________________________

PRE TREATMENT SCREENING:

Tuberculosis Screening: Date/Results of TB test_______________
Hepatitis B Screening: Date/ Results:__________________
Hepatitis C Screening: Date/Results:__________________

PRIOR MEDICATIONS TRIED AND FAILED :

Is your patient currently taking or failed any of the following RA products? Please circle.
Acetaminophen, ibuprofen, naproxen sodium, or other over the counter pain relievers- Currently taking or failed

Actemra- Currently taking or Failed	Celebrex- Currently taking or Failed
Cimzia- Currently taking or Failed	Corticosteroids-- Currently taking or Failed
Enbrel- Currently taking or Failed	Humira--------Currently taking or Failed
Leflunamide-- Currently taking or Failed	Orencia--Currently taking or Failed
Naproxen-----Currently taking or Failed	Remicade------- Currently taking or Failed
Prednisone----Currently taking or Failed	Rituxan-----Currently taking or Failed
Other___________________________	Sulfasalazine--Currently taking or Failed

Methotrexate-Currently taking Yes or No -must be taken in conjunction with Simponi ARIA****

STANDARD ORDERS

Dose/Frequency-Infuse Simponi Aria-2mg/kg in NS 100ml over 30 minutes at week 0, week 4 and every 8 weeks thereafter for 1 year. Upon completion of Simponi Aria infusion, infuse Normal Saline 20ml to clear line.

Patient weight _________lbs ________kg

Anaphylactic meds available at the chairside and Vital Sign Monitoring per Intravene Protocol

Signature, prescribing MD ______________________________ Date ___________________