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. 3001

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_____
_____
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 _____