



# Simponi

Provider Order Form

## PATIENT INFORMATION

Patient Name:		DOB:	
Patient Home Phone:		Patient Cell Phone:	Patient Email:
Address:	City:	State:	Zip Code:
Emergency/Alternate Contact Name:		Emergency/Alternate Contact Phone:	
NKDA	Allergies:	Weight lbs/kg:	Height:
Patient Status:	New to Therapy	Continuing Therapy	Therapy Change
Last infusion date (if applicable):			

## REQUIRED DOCUMENTATION

Labs                      Insurance Card (front and back)                      Current Medications                      History/Progress Notes

## ICD-10 CODE

Rheumatoid Arthritis                      Psoriatic Arthritis                      Ankylosing Spondylitis  
 Other: \_\_\_\_\_

## PRE-MEDICATION ORDER

<b>Acetaminophen</b> (Tylenol)	500mg	650mg	1000mg PO	<b>Diphenhydramine</b> (Benadryl)	25mg	50mg	PO	IV
<b>Cetirizine</b> (Zyrtec)	10mg PO			<b>Methylprednisolone</b> (Solu-Medrol)	40mg IV	125mg IV		
<b>Loratadine</b> (Claritin)	10mg PO			<b>Hydrocortisone</b> (Solu-Cortef)	100mg IV			
Other: _____		Dose: _____		Route: _____		Frequency: _____		

## MEDICATION ORDER

**Simponi Aria:**  
**Initial Dosing**      Simponi Aria 2mg/kg IV at Week 0, 4 then every 8 weeks thereafter  
**Maintenance Dosing**      Simponi Aria 2mg/kg IV every 8 weeks      Other: Simponi Aria      IV      every weeks

## PROVIDER INFORMATION

Provider Name:		Provider Email:		
Ordering Provider:		Provider NPI:		
Referring Practice Name:		Phone:	Fax:	
Practice Address:		City:	State:      Zip:	

## SPECIAL INSTRUCTIONS

\_\_\_\_\_  
**Provider Name**                                      **Provider Signature**                                      **Date**                                      Check here if this is a stat order

Order is valid for 1 year from date of signature and refills will be provided to cover the duration of treatment unless otherwise indicated.