PREMIER VITALITY

Physician-led - Patient-centered Infusion-care

Please fax completed form, insurance card, and clinical documentation to:
FAX: 410-220-2553

SIMPONI ARIA ORDER

☐ **New Start** ☐ **Maintenance: Last Dose Given**_____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies ☐ NKDA ☐ Allergies:

_____ Height:

_____ Weight: _____

Indication:

☐ M05.79 RA with rheumatoid factor of multiple sites w/o organ involvement
☐ M06.09 RA w/o rheumatoid factor, multiple sites
☐ M45.9 Active Ankylosing Spondylitis
☐ L40.52 Active Psoriatic Arthritis (PsA)
☐ Other _____

DRUG:

☐ Loading doses: 2mg/kg at weeks 0 and 4 followed by every 8 weeks
☐ Maintenance only: 2mg/kg every 8 weeks
☐ Other_____

PREMEDICATION ORDERS: *not required by PI*

☐ Acetaminophen po: ☐ 1000mg ☐500mg 30 min prior to infusion.
☐ Diphenhydramine: ☐ 25mg PO ☐ 50mg PO ☐ 25mg IVP 30 min prior to infusion. ☐
Solu-Medrol: ☐ 62.5mg IVP ☐ 100mg IVP ☐ Other_____ 30 min prior to infusion.

☐ Other _____

Prescriber Name:	Title:
NPI:	DEA:
Prescriber Signature:	Date of Order:

Referrals will not be processed until we receive <u>ALL</u> the following:

☐ Face Sheet / Patient Demographics

☐ Insurance card(s) – copy of front & back

☐ Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:

☐ CBC ☐ CMP ☐ Lipids ☐ TB ☐ Hep B Other: _____