

Simponi Aria



Ph: 518-836-3030 | Fax: 518-836-3020

Date: \_\_\_\_\_

Please include the following to expedite the order

Demographics, Insurance Information, Current CBC & CMP, Last Progress Note Relevant to the Diagnosis, Current Medications, Viral Hepatitis Results, TB Results

**PATIENT INFORMATION**

**PRESCRIBER INFORMATION**

Patient Name: \_\_\_\_\_

Prescriber's Name: \_\_\_\_\_

Patient Contact Number: \_\_\_\_\_

NPI: \_\_\_\_\_ Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Allergies: \_\_\_\_\_

Office Address: \_\_\_\_\_

Weight: \_\_\_\_\_ ○ lbs ○ kg Height: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Diagnosis: \_\_\_\_\_

Contact Email: \_\_\_\_\_

ICD 10: \_\_\_\_\_

☐ Please check this box if you **DO NOT** authorize UHO to complete a Peer-to-Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.

**PREMEDS**

☐ No Premeds

Benadryl:                      ☐ PO   ☐ IV                      ☐ 25 mg   ☐ 50 mg

Acetaminophen:           ☐ PO                      ☐ 650 mg   ☐ Other: \_\_\_\_\_

Methylprednisolone:    ☐ IV                      ☐ \_\_\_\_\_ mg

Other: \_\_\_\_\_

☐ You authorize UHO to utilize the hypersensitivity protocol established by UHO.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## SIMPONI ARIA DOSAGE

Date of Last Treatment, if Continuation: \_\_\_\_\_

Route: IV

Dose: 2 mg/kg

☐ Loading Frequency                      0, 4, then q8 weeks

☐ Maintenance                              Every 8 weeks

Refills: ☐ 3 months                      ☐ 6 months

(if not indicated order will expire 6 months from date signed)

***To ensure that a Brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on prescription form. If not indicated, UHO is authorized to administer generic or biosimilar.***

## LAB ORDERS

☐ No Labs

List: \_\_\_\_\_

Frequency: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_