PRIMERA SPECIALTY INFUSION

SIMPONI ARIA REFERRAL FORM

Patient Name _____
Date of Birth _____
Gender at Birth ◯ Male ◯ Female
Address _____
City, State, Zip _____
Phone _____
Email _____
Primary Insurance _____
Secondary Insurance _____

Prescriber Name _____
NPI # _____ DEA # _____
State Lic # _____ UPI # _____
Practice Name _____
Address _____
City, State, Zip _____
Office Contact _____
Office Contact Phone _____
Office Contact Email _____

CLINICAL INFORMATION

Primary Diagnosis/ICD10 _____
Diagnosis Date _____
Prior Therapies/Duration of Use _____
Current Therapy _____
Current Directions _____
Access Type ☐ Peripheral IV ☐ PICC ☐ Implant Port ☐ Broviac/Hickman
Last Dose _____ Height _____
Weight _____ Next Dose _____
Negative HBV ☐ Yes ☐ No Test Date:_____ Negative TB ☐ Yes ☐ No Test Date: _____
CBC/CMP ☐ Yes ☐ No Date of Test:_____ ESR/CRP ☐ Yes ☐ No Date of Test:_____ HLA-B27 ☐ Yes ☐ No Date of Test:_____
Rheumatoid Factor (RF) ☐ Yes ☐ No Date of Test:_____ Anti-CCP ☐ Yes ☐ No Date of Test:_____

PRESCRIPTION INFORMATION

Medication	**SIMPONI ARIA®**
Directions	▫ **Moderate to Severe Rheumatoid Arthritis (RA)** ▫ **Active Psoriatic Arthritis (PsA)** ▫ **Active Ankylosing Spondylitis (AS)** Dose: ☐ 2mg/kg Total dose:_____ **mg** Quantity: #3 Refills: 0 Directions: **Administer _____ mg (80 mg/m²) intravenously over 30 minutes at Week 0 and Week 4, then every 8 weeks thereafter.** Administration Rate: ☐ Per Prescribing Information, as tolerated ☑ Other: _____ ☐ **Pediatric patients with polyarticular Juvenile Idiopathic Arthritis and Psoriatic Arthritis (pJIA)** Dose: ☐ 80 mg/m² IV Body Surface Area (BSA): _____ m² Total Dose: _____ mg Quantity: #3 Refills: 0 Directions: Administer_____ mg intravenously over 30 minutes at Week 0, 4, and then 8 weeks Administration Rate: ☐ Per Prescribing Information, as tolerated ☐ Other: _____
Pre-Medications	☐ Acetaminophen 650mg 30 minutes prior to infusion PO ☐ Diphenhydramine 25mg 30 minutes prior to infusion ☐ PO ☐ IV ☐ Solu-Cortef _____mg slow IVP ☐ Solu-Medrol _____mg slow IVP Administered: ☐ Pre ☐ Halfway ☐ Upon Completion
Anaphylaxis Orders & Medications	Orders: 1. Stop Infusion 2. Call 911 and prescribing physician 3. Administer medications per protocol Diphenhydramine 50mg/mL slow IVP/IM Administer 12.5mg (wt.<15kg), Administer 25mg (wt.15-30kg) Administer 50mg (wt. > 30kg) Qty 1 Epinephrine 1mg/mL- Administer___ mg (wt. < 15kg) IM, Administer 0.15mg (wt. 15-30kg) IM, Administer 0.3mg (wt. > 30kg) IM Qty: 2 Sodium Chloride 0.9% – Administer 250mL IV at KVO (20ml/hr)
Flushing Protocol	☐ Sodium Chloride 0.9% 5-10mL pre and post medications ☐ Heparin_____Units/mL _____mL as needed
Pump and Ancillary Supplies	☐Pump and supplies as needed for administration and appropriate disposal of infusion materials
Skilled Nursing Visits	☐ As needed for IV access, administration and appropriate clinical monitoring

In order for brand name product to be dispensed when generic is available, prescriber must handwrite "Dispense As Written" to prohibit substitution. By signing below, I certify that the above therapy is medically necessary and that the provided medical information is accurate to the best of my knowledge. I authorize Primera Specialty Infusion to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for patient listed above. I understand that I can revoke this designation by providing notice to Primera Specialty Infusion.

Phone (689) 303-3338 Fax (689) 303-3240 Mail 795 Primera Blvd, Ste 1011, Lake Mary, FL 32746

Prescriber Signature _____ Date _____