LOWCOUNTRY
Rheumatology
A Member of Articularis Healthcare Group,Inc.

Please fax completed form, insurance card, and clinical documentation to:
FAX: (843) 793-6181

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: ____