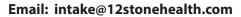
## **TwelveStone Health Partners**

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012





SIMPONI ARIA ORDER FORM						
Date:		ICD-10 Code:		Therapy Status		
Patient Name:		Allergies:		☐ New Start		
Date of Birth:		Weight:kg		☐ Continuing Therapy:  Last Dose:		
PROVIDER INFORMATION						
Ordering Pro		Provider Fax:	Provider Fax:			
Provider NPI:			Provider Address:	Provider Address:		
Provider Phone:						
MEDICATION ORDER						
Simponi Aria	<ul> <li>□ Initiation:         Administer Simponi Aria 2mg/kg IV over 30 minutes at weeks 0 and 4 per protocol.</li> <li>□ Maintenance:         Administer Simponi Aria 2mg/kg IV over 30 minutes every 8 weeks per protocol.</li> </ul>		Refills for one year from date of signature unless indicated below. Refills		Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:  ✓ Hepatitis B Surface Antigen.  ✓ Negative TB Quantiferon Gold, or TB Skin Test within the last 12 months.	
PRE-MEDICATIONS						
Oral         □ Acetaminophen:325mg500mg650mg         □ Loratadine: 10mg         □ Cetirizine: 10mg         □ Diphenhydramine:25mg50mg         □ Famotidine:20mg40mg         □ Ibuprofen:200mg400mg600mg         □ Ondansetron:4mg8mg         □ Other:			□ Diphenhy □ Famotidin □ Methylpre □ Hydrocort □ Ondanset	□ Dexamethasone:4mg8mg □ Diphenhydramine:25mg50mg □ Famotidine:20mg40mg □ Methylprednisolone: 125mg □ Hydrocortisone: 100mg □ Ondansetron:4mg8mg		
LAB ORDERS (please indicate any labs to be drawn and frequency)			OTI	OTHER REQUIRED DOCUMENTATION		
**Surveillance lab ordering and monitoring is the responsibility of the prescriber**  By signing below, I certify that the above therapy is medi  By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as m  to payors with respect to this patient and prescription order. This enrollment  Dispense as Written:			to 800-223-406         • History & Phy         • Patient Demo         • Medication Li         • Recent Lab V          edically necessary.         s my designated agent ir         ment form shall serve as	lically necessary. Prescriber's Signature (SIGN BELOW) by designated agent in submitting prior authorizations and other clinically required information		
Prescriber Signa	ature	Date	-   ———————————————————————————————————	nature	 Date	