

**Simponi Aria Enrollment Form**

**TwelveStone Health Partners**

**Fax Referral To:  
(800) 223-4063**



Date: \_\_\_\_\_  
Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_

Direct Phone: (615) 278-3350  
Toll Free: (844) 893-0012

**PREVIOUS ADMINISTRATION**

**If YES, please provide the following information:**

Last Infusion Date: \_\_\_\_\_  
Next Infusion Date: \_\_\_\_\_

**If NO, please indicate desired location for first dose:**

Physician's Office  
TwelveStone Infusion Center:  
 Canton  Chattanooga  Knoxville  Mount Juliet  Murfreesboro  
 Other: \_\_\_\_\_  
Desired Start Date: \_\_\_\_\_

**DIAGNOSIS**

**Description**

Rheumatoid Arthritis

**ICD-10 Code**

M06.9  Other: \_\_\_\_\_

**OTHER REQUIRED DOCUMENTATION (Please attach documents as needed)**

This signed order form  History and Physical  
 Patient Demographics and Insurance Information  Clinical progress notes, lab work (including most recent renal function tests and any other tests supporting primary diagnosis)

**CLINICAL INFORMATION (Please attach all clinical information, lab results and other medical history documents)**

Patient Weight: \_\_\_\_\_ Kg Height: \_\_\_\_\_ Inches/CM BSA: \_\_\_\_\_ Allergies: \_\_\_\_\_

Line Access:  PIV  PICC (SL DL TL)  PORT (Huber size \_\_\_\_\_ Gauge \_\_\_\_\_ Length)  Sub-Q

**MEDICATION DOSE DIRECTIONS REFILLS BASELINE LABWORK REQ'D TO INITIATE (Check for TwelveStone to draw)**

<input type="checkbox"/> Simponi Aria	50mg/4ml Vial	<input type="checkbox"/> <u>Initiation</u> - Infuse 2mg/kg ( _____ mg) IV over 30 minutes at weeks 0 and 4.		<input type="checkbox"/> CBC w/Differential  <input type="checkbox"/> TB QuantiFERON Gold
		<input type="checkbox"/> <u>Maintenance</u> - Infuse 2mg/kg ( _____ mg) IV over 30 minutes every 8 weeks		

**LAB ORDERS - To be drawn by TwelveStone**

<u>Order</u>	<u>Frequency</u>
CBC w/Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CBC w/o Differential	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
BMP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
CRP	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Sed Rate	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Calcium	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Tb QuantiFERON Gold	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Hepatitis Panel	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____
Other _____	<input type="checkbox"/> One Time Prior to Treatment <input type="checkbox"/> Every Treatment <input type="checkbox"/> Q _____ Weeks <input type="checkbox"/> Other _____

**PRE-MEDICATIONS - \*RECOMMENDED/Check Here if NO Pre-Meds \_\_\_\_\_**

<u>Oral</u>	<u>IV</u>
Acetaminophen: <input type="checkbox"/> 325mg <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg	Dexamethasone: <input type="checkbox"/> 10mg
Cetirizine: <input type="checkbox"/> 10mg	Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg
Diphenhydramine: <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg	Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg
Famotidine: <input type="checkbox"/> 20mg <input type="checkbox"/> 40mg	Methylprednisolone: <input type="checkbox"/> _____mg IV over _____ mins
Ibuprofen: <input type="checkbox"/> 200mg	Ondansetron: <input type="checkbox"/> 4mg <input type="checkbox"/> 8mg
Loratadine: <input type="checkbox"/> 10mg	
Ondansetron: <input type="checkbox"/> 4mg	

**By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)**

Physician's Phone # \_\_\_\_\_ Physician's NPI# \_\_\_\_\_ Physician's Fax # \_\_\_\_\_ Physician's Address \_\_\_\_\_  
Dispense as Written \_\_\_\_\_ Date \_\_\_\_\_ Substitution Allowed \_\_\_\_\_ Date \_\_\_\_\_

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