

TwelveStone Health Partners

Fax Referral To: (615) 278-3355

Direct Phone: (844) 893-0012

Email: intake@12stonehealth.com



SIMPONI ARIA ORDER FORM

Date: _____ ICD-10 Code: _____
 Patient Name: _____ Allergies: _____
 Date of Birth: _____ Weight: _____ lbs OR _____ kg

Therapy Status
 New Start
 Continuing Therapy:
 Last Dose: _____

PROVIDER INFORMATION

Ordering Provider: _____ Provider Fax: _____
 Provider NPI: _____ Provider Address: _____
 Provider Phone: _____

MEDICATION ORDER

Simponi Aria

Initiation:
 Administer Simponi Aria 2mg/kg IV over 30 minutes at weeks 0 and 4 per protocol.
 Maintenance:
 Administer Simponi Aria 2mg/kg IV over 30 minutes every 8 weeks per protocol.

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: _____ 325mg _____ 500mg _____ 650mg
 Loratadine: 10mg
 Cetirizine: 10mg
 Diphenhydramine: _____ 25mg _____ 50mg
 Famotidine: _____ 20mg _____ 40mg
 Ibuprofen: _____ 200mg _____ 400mg _____ 600mg
 Ondansetron: _____ 4mg _____ 8mg
 Other: _____

IV
 Dexamethasone: _____ 4mg _____ 8mg
 Diphenhydramine: _____ 25mg _____ 50mg
 Famotidine: _____ 20mg _____ 40mg
 Methylprednisolone: 125mg
 Hydrocortisone: 100mg
 Ondansetron: _____ 4mg _____ 8mg
 Other: _____

LAB ORDERS (please indicate any labs to be drawn and frequency)

OTHER REQUIRED DOCUMENTATION

Surveillance lab ordering and monitoring is the responsibility of the prescriber

(Please fax this signed order form, along with the following documents to 800-223-4063)
 • History & Physical, Last Office Visit Note
 • Patient Demographics and Insurance Information
 • Medication List
 • Recent Lab Work

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

By signing this form, I am authorizing TwelveStone Health Partners and affiliates to serve as my designated agent in submitting prior authorizations and other clinically required information to payors with respect to this patient and prescription order. This enrollment form shall serve as my signature for prior authorizations, as requested.

Dispense as Written:

 Prescriber Name _____ Date _____

Substitution Allowed:

 Prescriber Name _____ Date _____