Comanche County Memorial Hospital

Outpatient Infusion Center
Simponi Aria Order

Please fax form to: 580-585-5472

Patient Information

Patient Name: DOB: Phone: Gender ☐ M ☐ F

Patient Address: Email: Insurance:

Additional Information Needed

☐ Fax front/back of insurance card ☐ Fax clinical/progress notes ☐ Fax labs

☐ Fax patient demographics ☐ Fax current medication list ☐ Fax TB and Hep B results

Diagnosis and Clinical Information

Diagnosis (ICD-10):

☐ L40.50 Arthropathic Psorasis, Unspecific
☐ L40.59 Other Psoriatic Arthropathy
☐ L40.52 Psoriatic Arthritis Multilans
☐ M06.9 Rheumatoid Arthritis, Unspecified
☐ M06.09 Rheumatoid Arthritis without Rheumatoid Factor, Multiple Sites
☐ M45.0 Ankylosing Spondylitis of Multiple Sites in Spine
☐ M45.9 Ankylosing Spondylitis of Unspecified Sites in Spine
☐ Other DX: _____

Clinical Information:

☐ New Therapy Induction ☐ Therapy Change ☐ Therapy Continuation

☐ Patient Weight: _____ lbs/_____ kg ☐ Patient Height: _____ in/ _____ cm

☐ Allergies: _____

☐ Therapies Tried and Failed: _____

☐ TB Test: Date: _____ Results: _____ ☐ Hep B Test: Date: _____ Results: _____

☐ Does the patient have venous access? Yes or No If yes, What type? _____

If no, Initiate IV access

Lab Orders

☐ CBC ☐ CMP ☐ ESR ☐ CRP ☐ HBsAg ☐ HBsAB ☐ HBcAB ☐ Quantiferon Gold

☐ Other: _____

☐ Infusion Services
☐ Referring Provider

Prescription Information

☐ Simponi Aria

☐ Inital Dose: 2mg/kg beginning week and week 4
☐ Maintenance Dose: 2mg/kg every 8 weeks after week 4

Misc Orders

☑ PICC/ Midline/ CAD dressing to be changed every 7 days.

☐ _____

☐ _____

☑ 10mL NS Flush Syringe PRN
☑ Heparin 500units/5mL Flush Syringe PRN
☑ 50ml NS Bag PRN
☑ 250ml NS Bag PRN

Standing Orders for Adverse Reactions

☑ Stop infusion and initiate NS bolus
☑ Notify Supervising physician and ordering provider
☑ Solu-Cortef 100mg SIVP signs of adverse reaction
☑ Benadryl 25mg SIVP for hives or bronchial inflammation
☑ Epi 1:1000 1mL IM, IV, or SQ for anaphylaxis
☑ Oxygen 2-5L nasal cannula
☑ Albuterol 2.5mg inhaled PRN for chest tightness
☐ Other: _____

Prescriber Information

Physician Name: _____ Office Contact Name: _____

Contact #: _____ Fax Number: _____

Address: _____ City/State/Zip: _____

NPI#: _____ DEA#: _____ State License #: _____

_____ _____

Physician's Signature Date Time