



Simponi Aria Order Form

Select patient referral location: Akron Athens Blue Ash Cleveland Columbus Crestview Hills
 Dayton Mansfield Perrysburg Springfield Toledo West Cincinnati

For new referrals, please include recent labs and last two office visit notes.

Fax completed form to 888-977-0914

Phone: 877-787-8720 • www.horizoninfusions.com

1. PATIENT INFORMATION

Name:		DOB:	
Phone:		Other Phone:	
Email:			
Social Security #:		Allergies:	
Gender:	M F	Weight:	Lbs Kg
Patient Status:		Next due date (if applicable):	
New to therapy		Continuing therapy	

2. INSURANCE INFORMATION (required)

Please submit copies of the front and back of primary and/or secondary insurance cards with this referral.

3. PHYSICIAN INFORMATION

Physician Name:		NPI#:	
License #:	TIN#:	DEA#:	
Address:			
City:		State	Zip
Office Contact:		Email:	
Office phone:		Office fax:	

4. DIAGNOSIS INFORMATION (and year of diagnosis)

Rheumatoid Arthritis (____) ICD 10 (____) Other: _____

5. PRESCRIPTION INFORMATION (requires new order every 12-months)

<p>Initial Maintenance</p> <p>Initial Dose: Administer 2mg/kg IV over 30 minutes at week 0 and 4; then every 8 weeks thereafter</p> <p>Maintenance Dose: Administer _____ mg at _____ mg/kg IV every _____ week(s)</p> <p>Vital signs per HI Protocol</p> <p>Anaphylaxis & Hydration Management per HI Protocol</p>	<p>PRE-MEDICATIONS N/A</p> <p>Acetaminophen 500mg 650mg 1000mg</p> <p>Fexofenadine (Allegra) 180mg PO (or other non-sedating antihistamine)</p> <p>Diphenhydramine (Benadryl) 25mg 50mg PO IV (requires driver)</p> <p>Methylprednisolone (Solu-Medrol) 40mg 80mg 125mg IV</p> <p>Prednisone _____ mg PO</p> <p>Other _____</p> <p>POST-MEDICATIONS N/A</p> <p>Acetaminophen 500mg 650mg 1000mg</p> <p>Prednisone _____ mg PO</p> <p>Other _____</p>
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6. LABS

CBC w/Diff	Each Infusion	Other Frequency (specify): _____
CRP	Each Infusion	Other Frequency (specify): _____
CMP	Each Infusion	Other Frequency (specify): _____
ESR	Each Infusion	Other Frequency (specify): _____
Hepatic Panel	Each Infusion	Other Frequency (specify): _____
Renal Panel	Each Infusion	Other Frequency (specify): _____
Quantiferon TB Gold, annually, last completed (date): _____		
Other (specify): _____		

7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE _____

DATE _____