

SIMPONI-ARIA REFERRAL FORM

PATIENT DEMOGRAPHICS:

PATIENT NAME:	PATIENT'S CONTACT #:
DATE OF REFERRAL:	ADDRESS:
DATE OF BIRTH:	CITY, STATE, ZIP:
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:	
HEIGHT: _____ FEET _____ INCHES	GENDER: FEMALE MALE
WEIGHT: _____ LB or _____ KG	ALLERGIES: SEE LIST NKDA

PRIMARY DIAGNOSIS:

M06.00 - Rheumatoid arthritis without rheumatoid factor, unspecified	M05.60 - Rheumatoid arthritis of unspecified site with involvement of organs and systems
M05.70 - Rheumatoid arthritis with rheumatoid factor of unspecified site without organ or systems involvement	
L40.50 - Arthropathic psoriasis, unspecified	L40.51 - Distal interphalangeal psoriatic arthropathy
L40.52 - Psoriatic arthritis mutilans	L40.59 - Other psoriatic arthropathies
M45.9 - Ankylosing spondylitis of unspecified sites in spine	Other

REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

<input checked="" type="checkbox"/> 1. INSURANCE CARD (Front & Back)	<input checked="" type="checkbox"/> 2. PATIENT DEMOGRAPHICS	<input checked="" type="checkbox"/> 3. MOST RECENT LABS	<input checked="" type="checkbox"/> 4. MEDICATION LIST	<input checked="" type="checkbox"/> 5. H & P
<input checked="" type="checkbox"/> 6. TRIED/FAILED THERAPIES	<input checked="" type="checkbox"/> 7. TB TEST RESULT			

PRIMARY MEDICATION ORDER:

Please include MEDICATION, DOSE, FREQUENCY, DURATION and any ADDITIONAL administration INSTRUCTIONS specific to the primary therapy.

Adult Rheumatoid Arthritis, Psoriatic Arthritis, or Ankylosing Spondylitis:

Simponi ARIA 2 mg/kg IV at week 0, 4, and every 8 weeks thereafter.

Pediatric Psoriatic Arthritis or Polyarticular Juvenile Idiopathic Arthritis:

Simponi ARIA 80 mg/m² IV at week 0, 4, and every 8 weeks thereafter.

Other: _____

FIRST DOSE: Y N

Refill x12 months unless otherwise noted.

PRN & PREMEDICATIONS:

MEDICATIONS	30 minutes prior to every infusion	PRN
Acetaminophen 650 mg PO		PRN every ___ hour for mild or moderate infusion reaction.
Diphenhydramine 25 mg PO		PRN every ___ hour for mild or moderate infusion reaction.
Diphenhydramine 25 mg IV		PRN every ___ hour for mild or moderate infusion reaction.
Methylprednisolone 125 mg IV		PRN every ___ hour for mild or moderate infusion reaction.
Other: _____		PRN every ___ hour for mild or moderate infusion reaction.

LINE USE/CARE ORDERS:

START PIV/ACCESS CVC

FLUSH DEVICE PER FLEXCARE INFUSION POLICY & PROCEDURE (SEE REVERSE SIDE)

OTHER FLUSH ORDERS: (please fax other reaction orders if checking this box)

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side)

OTHER: (please fax other reaction orders if checking this box)

PRESCRIBER INFORMATION: Please check preferred form of communication.

PROVIDER NAME:	PHONE:
OFFICE CONTACT:	FAX:
ADDRESS:	EMAIL:
CITY, STATE, ZIP:	NPI:

➔ (GENERIC SUBSTITUTION PERMITTED)

PROVIDER SIGNATURE:

DATE:

➔ (DISPENSE AS WRITTEN)

PROVIDER SIGNATURE:

DATE:

SIMPONI-ARIA REFERRAL FORM

FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

**This table does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INFUSION REACTION	MODERATE INFUSION REACTION	SEVERE INFUSION REACTION/ANAPHYLAXIS
SYMPTOM CLASSIFICATION	<ul style="list-style-type: none"> Flushing Dizziness Headache Apprehension Diaphoresis Palpitations Nausea / Vomiting Pruitis 	<ul style="list-style-type: none"> Chest Tightness Shortness of Breath Hypo/hypertension (>20 mmHg Change in Systolic BP from Baseline) Increased Temperature (>2 Degrees Fahrenheit) Urticaria 	<ul style="list-style-type: none"> Hypo/hypertension (>40 mmHg Change in Systolic BP from Baseline). Increase Temperature (>2 Degrees Fahrenheit) with Rigors Shortness of Breath with Wheezing Laryngeal Edema Chest Pain Hypoxemia
TREATMENT PROTOCOL FOR ADULTS >66LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midanterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min <input checked="" type="checkbox"/> Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium	
		0.9% Sodium Chloride		10 Units/mL	100 Units/mL
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*
ADULT > 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	10 mL	10 mL	5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL
PEDIATRIC 33 LBS - 66 LBS	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	5 mL	10 mL	3 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL

FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.

*0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.