

Simponi IV Order Form—J1602

Patient Name	Middle	Last	DOB
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Diagnosis	Diagnosis Code
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Height (cm)	Actual Weight (kg)	Allergies
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Please list any premeds needed.

*Required labs: TB screening prior to treatment then yearly, HBV screening prior to therapy and CBC with differential prior to therapy then every 3 to 6 months.

- Psoriatic arthritis, Rheumatoid Arthritis and Ankylosing Spondylitis:** IV: 2 mg/kg at weeks 0, 4, and then every 8 weeks thereafter. *Vial size is 50 mg/4ml please dose accordingly*

Simponi Aria 2 mg/kg IV: Initial 4 Weeks q8 Weeks

Orders valid through: _____

In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.

Provider Name	Provider Signature
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Date	Phone	Fax	Pager
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