NEW ENGLAND
Cancer Specialists

Infusion Center

KENNEBUNK | ROCK ROW | TOPSHAM | PORTSMOUTH
PHONE: (207) 303-3225 | FAX: (207) 692-2473

Simponi IV Order Form—J1602

Patient Name | Middle | Last | DOB

Diagnosis | Diagnosis Code

Height (cm) | Actual Weight (kg) | Allergies

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

Date | Phone | Fax | Pager