Simponi Aria

RHEUMATOLOGY CONSULTANTS of WNY

WNY Infusion Center

PROVIDERS: Please include the following to expedite the order:
Patient Demographics, Most Recent Office Visit Note, Insurance Information, TB test, Hep B test

Please check "X" if applicable

PATIENT INFORMATION

Referral Status: _____New Referral _____Updated Order _____Order Renewal

Date: Patient Name: Patient Phone: DOB:

ICD-10 code (required): ____M06.9 ____L40.53 ____M45.9 ____M08.3 ICD Description:

Allergies: Weight (lbs/kg): Height:

Patient Status: ____ New to therapy ____ Continuing Therapy Last Treatment Date: Next Due date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip:

NURSING (All required)

➔ TB Status and Date (list results & attached clinicals)

_____

➔ Hepatitis B Status and Date (list results & attached clinicals)

_____

LABORATORY ORDERS

___ CBC ___ at each dose ___every _____

___ CMP ___ at each dose ___every _____

___Other_____ ___every _____

___ Please "X" if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or Insurance authorization prior to treatment

PRE-MEDICATION ORDERS

Pre-medications not usually indicated

☐ Diphenhydramine ___ 25mg / ___50mg ___PO/___IV
☐ Acetaminophen ___325mg / ___500mg / ___650mg PO
☐ Other _____

Dose:_____ Route: _____Frequency: _____

THERAPY ADMINISTRATION

-Rituxan Intravenous Infusion
Dose: ___2mg/kg or ___total dose:_____mg
Frequency:
____Induction: Week 0, 4, then
____Maintenance : Every 8 weeks
Refills: ____Zero / ____for 12 months / ____ _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispense, the prescriber must handwrite"Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print)	Provider Signature	Date