

Patient Information

Name: _____ DOB: _____
Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____
Email: _____ Weight: _____ ☐ lbs ☐ kgs
Allergies: ☐ NKDA ☐ _____

Required Documentation Insurance Card | History & Physical | Patient Demographics | Medication List | Most Recent Labs
Tried and Failed Therapies (including duration) | Negative TB Results

Primary Diagnosis

- | | |
|---|--|
| <input type="checkbox"/> L40.50 Arthropathic psoriasis, unspecified | <input type="checkbox"/> M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites |
| <input type="checkbox"/> L40.52 Psoriatic arthritis mutilans | <input type="checkbox"/> M06.89 Other specified rheumatoid arthritis, multiple sites |
| <input type="checkbox"/> M05.79 Rheumatoid arthritis with rheumatoid factor multiple sites without organ/system involvement | <input type="checkbox"/> M06.9 Rheumatoid arthritis, unspecified |
| <input type="checkbox"/> M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified | <input type="checkbox"/> M45.0 Ankylosing spondylitis of multiple sites in spine |
| | <input type="checkbox"/> Other: _____ |

Order Information**Lab Orders** (Include frequency)

Please list any labs to be drawn by the infusion clinic: _____

Pre-Medications

- ☒ Per infusion clinic protocol, there are no recommended standard pre-meds for Simponi ARIA
☐ Provider Prescribed: _____

Primary Medication Order

- ☐ Simponi ARIA 2mg/kg (_____mg) IV at week 0, 4, and every 8 weeks thereafter
☐ Simponi ARIA _____mg/kg (_____mg) IV every _____ weeks thereafter
☐ Other: _____
First Dose: ☐ Yes ☐ No ☒ Refill x12 months unless otherwise noted: _____

Line Use/Care Orders

- ☒ Start PIV/ACCESS CVC ☒ Flush device per BluHaven Health's protocol (see BluHaven.com for policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box.

Adverse Reaction & Anaphylaxis Orders

- ☒ Administer acute infusion reaction and anaphylaxis medications per BluHaven Health's protocol (see BluHaven.com for policy)
☐ Other: Please fax other reaction orders if checking this box.

Provider Information

Name: _____ Office Contact: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number: _____
Email: _____ NPI: _____

I authorize BluHaven Health and its representatives to act as an agent to initiate and execute the insurance prior authorization process for this order and any future related orders for the patient listed above.

Provider Signature_____
Date