FAX REFERRAL: **800-970-6020**

Simponi Aria Referral Checklist

Date:____/____/____.

Referring Physician:____________________________________.

Physician's Telephone #:_____________________________Facsimile #:________________________.

Patient's Name:___________________________Date of Birth:____/____/____.

- ☐ Patient Demographics
- ☐ Most Recent Office Visit Note
- ☐ Most recent Tb test. If not completed, patient can receive it at our office
- ☐ Diagnosis:
  - ☐ Rheumatoid Arthritis – Please specify ICD 10 diagnosis
    - ☐ M05.7-
    - ☐ M05.69
    - ☐ M05.89
    - ☐ M05.9
    - ☐ M06.09

Dosage: Weight Based

- ☐ Initiation – Simponi Aria 2 mg/kg IV at 0, 4, then every 8 weeks thereafter
- ☐ Maintenance – 2 mg/kg IV infusion Q 8 weeks

Please specify dosage:____mg/kg IV Q 8 weeks

Office Staff Name:_____________________________Signature__________________________.