



Physician-led - Patient-centered Infusion-care

Please fax completed form, insurance card, and clinical documentation to:
FAX: 410-220-2553

ORENCIA ORDER

New Start **Maintenance: Last Dose Given** _____

Referring Office:	Contact Name:	Date:
Direct Phone for Contact:	Fax:	
Patient Name:	DOB:	

Allergies NKDA Allergies:

_____ Height: _____

_____ Weight: _____

Indication:

M05.7 ___ RA with RF of multiple sites w/o organ involvement

M05.8 ___ Other RA w/ RF

M06.0 ___ RA w/o RF, multiple sites

L40.5 ___ Psoriatic Arthritis

Other _____

DOSAGE ORDERS:

500mg (<60 kg or 132 lb) IV at 0,2, 4 and Q 4 weeks

750mg (60kg-100 kg or 132 lb-220 lb) IV at 0,2, 4 and Q 4 weeks

1000mg (>100 kg or 220 lb) IV at 0,2, 4 and Q 4 weeks

Other _____

PREMEDICATION ORDERS: *not required by PI*

Acetaminophen po: 1000mg 500mg 30 min prior to infusion.

Diphenhydramine: 25mg PO 50mg PO 25mg IVP 30 min prior to infusion.

Solu-Medrol: 62.5mg IVP 100mg IVP Other _____ 30 min prior to infusion.

Other _____

Prescriber Name: Title:	
NPI:	DEA:
Prescriber Signature: Date of Order:	

Referrals will not be processed until we receive ALL the following:

- Face Sheet / Patient Demographics
- Insurance card(s) – copy of front & back
- Last 2 clinic notes pertaining to referring diagnosis (include ALL past & failed therapy outcomes) Most Recent Labs (within last 4-8 weeks) – Required:
- CBC CMP TB Hep B Other: _____