PREMIER VITALITY

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 inolvement
- ☐ 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 <u>ALL</u> 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: