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Ascend
INFUSION CENTERS

Please fax completed form, insurance card, and clinical documentation to:
FAX: 843-793-6181

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: ____