



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 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:**

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

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

Methylprednisolone:  62.5mg IVP    125mg 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: \_\_\_\_\_