



## Orencia Order Form

Select patient referral location: ☐ Akron ☐ Blue Ash ☐ Cleveland ☐ Columbus ☐ Crestview Hills ☐ Springfield ☐ West Cincinnati  
☐ Other \_\_\_\_\_

Fax completed form to 888-977-0914. For new referrals, please **include recent labs and last two office visit notes.**

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### 1. PATIENT INFORMATION

Name:	DOB:
Home phone:	Other phone:
Email:	
Social Security #:	Allergies:
Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Weight: <input type="checkbox"/> Lbs <input type="checkbox"/> Kg
Patient Status: <input type="checkbox"/> New to therapy <input type="checkbox"/> Continuing therapy <input type="checkbox"/> Next due date (if applicable):	

### 2. PHYSICIAN INFORMATION

Physician's name:		NPI#:
License #:	TIN#:	DEA#:
Address:		
City:	State:	Zip:
Office contact:	Email:	
Office phone:	Office fax:	

### 3. DIAGNOSIS INFORMATION (and year of diagnosis)

<input type="checkbox"/> Rheumatoid Arthritis ( _____ )	<input type="checkbox"/> Juvenile Idiopathic Arthritis ( _____ )
<input type="checkbox"/> ICD 10 ( _____ )	<input type="checkbox"/> Other (specify): _____

### 4. INSURANCE INFORMATION

Please submit copies of the front and back of primary and secondary insurance cards with this referral.

### 5. PRESCRIPTION INFORMATION (requires new order every 12 months)

<b>ORENCIA</b> <input type="checkbox"/> Initial <input type="checkbox"/> Maintenance	<b>PRE-MEDICATIONS</b> <input type="checkbox"/> N/A
<input type="checkbox"/> Initial Dose: Administer at week 0, followed by week 2 and week 4 <input type="checkbox"/> 500mg (2 vials) <input type="checkbox"/> 750mg (3 vials) <input type="checkbox"/> 1000mg (4 vials)	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
<input type="checkbox"/> Maintenance Dose: Administer every 4 weeks <input type="checkbox"/> 500mg (2 vials) <input type="checkbox"/> 750mg (3 vials) <input type="checkbox"/> 1000mg (4 vials)	<input type="checkbox"/> Fexofenadine (Allegra) 180mg PO (or other non-sedating anti-histamine)
Infuse over 30 minutes <b>OR</b>	<input type="checkbox"/> Diphenhydramine (Benadryl) <input type="checkbox"/> 25mg <input type="checkbox"/> 50mg <input type="checkbox"/> PO <input type="checkbox"/> IV (requires driver)
<input type="checkbox"/> Infuse at _____	<input type="checkbox"/> Methylprednisolone (Solu-Medrol) <input type="checkbox"/> 40mg <input type="checkbox"/> 80mg <input type="checkbox"/> 125mg IV
	<input type="checkbox"/> Prednisone _____ mg PO
<input type="checkbox"/> Vital signs per HI Protocol	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Anaphylaxis & Hydration Management per HI Protocol	<b>POST-MEDICATIONS</b> <input type="checkbox"/> N/A
	<input type="checkbox"/> Acetaminophen <input type="checkbox"/> 500mg <input type="checkbox"/> 650mg <input type="checkbox"/> 1000mg PO
	<input type="checkbox"/> Prednisone _____ mg PO
	<input type="checkbox"/> Other: _____

### 6. LABS

<input type="checkbox"/> CBC w/Diff	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CRP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> CMP	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> ESR	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Hepatic Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Renal Panel	<input type="checkbox"/> each infusion	<input type="checkbox"/> Other frequency (specify): _____
<input type="checkbox"/> Quantiferon TB Gold, annually, last completed (date): _____		
<input type="checkbox"/> Other (specify): _____		

### 7. SIGNATURE (required)

PHYSICIAN'S SIGNATURE

DATE