RECOVERY ROOM IV THERAPY, LLP.

Phone: 480-865-3322 Fax: 480-866-8189

Orencia Referral Order Form

Patient Information

Patient Name:	Patient DOB:
Patient Phone #:	Sex of Patient:

Provider Information

Ordering Provider Name:	NPI # of Prescribing Provider:
Office Contact Name:	Office Phone #:
Office Fax #:	

Orencia Medication Orders

Dosage

- < 60kg: ___ (Initial) 500mg IV at weeks 0,2 and 4 then every 4 weeks thereafter or ___ (Maintenance) 500mg IV every 4 weeks
- 60 to 100kg: ___ (Initial) 750mg IV at weeks 0,2 and 4 then every 4 weeks thereafter or ___ (Maintenance) 750mg IV every 4 weeks
- > 100kg: ___ (Initial) 1000mg IV at weeks 0,2 and 4 then every 4 weeks thereafter or ___ (Maintenance) 1000mg IV every 4 weeks
- Other _____

Patient Weight: _____ Lbs or _____ Kg

Diagnosis with ICD 10 code **(REQUIRED)**

- Diagnosis: _____ Rheumatoid Arthritis (RA) ____ Psoriatic Arthritis ____ Other _____
- ICD 10 code _____

Pre-Medication	Refills
○ Tylenol _____mg ○ Benadryl _____ mg __IV or ___PO ○ Solumedrol IV Push _____ mg ○ Other _____	○ Zero _____ ○ 12 _____ ○ Other _____

Required Documentation

○ Insurance Cards (Front and Back) **○ Demographics** **○ Recent Progress Notes**
○ Lab Results – CMP, CBC, TB and Hep B Screening

Special Instructions/Notes

_____ _____

Prescribing Provider Signature **Date of Signature**