

# LOWCOUNTRY Rheumatology

A Member of Articularis Healthcare Group, Inc.

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:** *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 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  Lipids  TB  Hep B Other: \_\_\_\_\_