# ORENCIA (ABATACEPT) Referral Order Form

FAX (855) 891-2191

Effective: 10/2016

# MPP Infusion Centers

www.mppinfusion.com

Referral Phone: (855) 478-1528 Referral Fax: (855) 891-2191

☐ Denver ☐ Arlington ☐ Dallas ☐ Duncanville ☐ Irving ☐ Lewisville ☐ Plano ☐ Southlake

☐ New Referral ☐ Restart ☐ Medication/ Order Change *(New Order Required)* ☐ Benefits Verification Only ☐ D/C Infusions **indicate name of drug(s)*

_____

## PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

## PHYSICIAN INFORMATION

Referring Physician: _____

Practice Name: _____

Specialty: _____

Office Contact: _____

Contact Phone # _____ Contact Fax # _____

Contact Email: _____

## ORENCIA MEDICATION ORDERS

Patient Weight: _____kg

☐ Initial/Reload Dosing: _____ mg IV on day 0, 2 weeks, 4 weeks then every ____ weeks.

☐ Maintenance Dosing: _____ mg IV every ____ weeks.

### INDICATION/DIAGNOSIS

☐ Rheumatoid Arthritis

☐ Other *(please specify in notes)*

***ICD-10 _____ required**

### NOTES (ADDITIONAL INFO)

_____ _____

Referring Physician's Signature Date

### STANDING LAB ORDERS

**Labs to be drawn by:**

☐ Referring Physician

☐ Infusion Center

**Orders:**

☐ CMP ☐ CBC ☐ CRP

☐ ESRP ☐ HFP ☐ UA

**Frequency:**

☐ Every Infusion

☐ Other _____

## REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication List ☐ History and Physical Report

☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

### ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ HepB Surf Ag (w/in 12 months) ☐ HepB Core Ab (w/in 12 months) ☐ PPD Results (w/in 6 months) ☐ Rheumatoid Factor

☐ Chest X-ray (if indicated) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

**APPOINTMENT DATE & TIME:** _____

***FOR OFFICE USE ONLY***