ORENCIA (ABATACEPT) Referral Order Form

FAX (877) 637-6691

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

Vasco Infusion can accept only original prescription drug orders from patients, and faxed prescriptions from the prescribing practitioners.

PATIENT INFORMATION

Name: _____ Date: _____

DOB: _____ SS# _____

Phone # _____

Email: _____

PHYSICIAN INFORMATION

Referring Physician: _____

Practice Address: _____

_____

OfficeContact: _____

Contact Phone # _____ Contact Fax # _____

NPI / TIN: _____ _____

ORENCIA MEDICATION ORDERS

Patient Weight: _____ kg

< 60kg :500mg
60-100kg : 750mg
> 100kg : 1000mg

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

☐ Maintenance Dosing:_____ mg IV every _____ weeks.

Refills: _____

INDICATION/DIAGNOSIS

☐ Rheumatoid Arthritis
☐ Other *(please specify in notes)*

***ICD-10** _____ **required**

NOTES (ADDITIONAL INFO)

_____
Referring Physician's Signature

_____
Date

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 12 months)

☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months

APPOINTMENT DATE & TIME: _____

FOR OFFICE USE ONLY