MPP Infusion Centers

A Multispecialty Physician Partner Company

Fax To: (855) 891-2191
Email To: MPPReferral@mppinfusion.com
Have a Question? Call: (855) 478-1528

ORENCIA® (ABATACEPT) ORDER FORM

REFERRAL STATUS

_____New Referral _____Order Renewal _____Restart _____Medication/Order Change _____Benefits Verification Only
_____D/C Infusion *(Medication(s) to D/C _____)*

LOCATION

_____Denver _____Arlington _____Dallas _____Duncanville _____Irving _____Lewisville _____Plano _____Southlake
_____Tyler

PATIENT INFORMATION

PATIENT NAME:	DOB:	SEX: _____MALE _____FEMALE
ADDRESS:	PHONE #:	
WEIGHT: ____ LBS ____ KG	HEIGHT:	EMAIL:
ALLERGIES:		

Please check that the following are included	____Patient demographics and insurance attached	____Clinical/Progress Notes, H&P, Labs, Tests, supporting DX Attached
	____Current Medication List	____TB Results (w/in 6 months)-*if positive, need negative chest Xray and negative TSpot*
	____ HepB Surf Ag (w/in 36 months) (For IBD diagnosis w/in 12 months)	

PHYSICIAN INFORMATION

Physician Name:	Email *(if you would like referral updates)*:
Practice Name:	Phone Number:
Office Contact:	Fax Number:

DIAGNOSIS

____Rheumatoid Arthritis	____Psoriatic Arthritis	____Other:

ICD-10 CODE:	**Date of last infusion/injection:**

MEDICATION ORDERS

ORENCIA ORDERS:	**Notes/Comments**
____ Initial/Reloading Dose: _____mg IV on day 0, 2 weeks, and 4 weeks, then every ____ weeks. ____ Maintenance Dosing: _____mg IV every _____weeks.	
Physician Signature _____ **Date (Order is Valid for One Year)**_____	

STANDING LAB ORDERS

_____Labs to be Drawn by Infusion Center Frequency: _____ Every Infusion _____Other (*please specify*) _____

_____CMP ____CBC _____CRP _____ESRP _____HFR _____UA