ORENCIA® Infusion Referral Form

University Hospitals Home Care Services

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Warrensville Heights, OH 44128
Phone: 800-552-8442
Fax: 216-201-5127

Please complete each section of the referral form below and fax along with a copy (front and back) of all of the patient's pharmacy and medical insurance cards, the patient's demographic face sheet, and any relevant clinical notes/documents.

Prescriber Info.

Prescriber: _____ **NPI:** _____

Phone: _____ **Fax:** _____ **Office Contact:** _____

Address: _____

_____

Patient Information

Name: _____ **DOB:** _____ ☐M ☐F

Address: _____

Phone: _____ **2nd Phone:** N/A _____ **MRN:** _____

Primary Language: _____ **Functional Limitations:** _____

Clinical Information

Diagnosis (Include ICD-10 Code): _____

Weight:_____ ☐lb ☐kg **Height:**_____ ☐in **IV access:** ☐PIV ☐PICC ☐Port ☐Other: _____

Patient's first dose? ☐Yes ☐No (If no, date of last dose: _____ Prior dose (in mg): _____)

Allergies: _____ **Latex allergy?** ☐Yes ☐No

Prior treatments & reason for discontinuation: _____

_____

Date of *negative* TB test: _____ ☐TB test pending, will fax results. **Patient is HBV negative or has been treated:** ☐Yes ☐No

History of kidney disease: ☐Yes ☐No If yes, SCr: _____ GFR/CrCl: _____ **History of heart failure:** ☐Yes ☐No

Referring provider's preferred site of care: ☐Home Care Infusion Center ☐Home Infusion ☐Home Care to determine site of care
Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.

Additional Notes: _____

_____

_____

Prescription Information

Orencia® dose: ☐500mg (<60kg) ☐750mg (60-100kg) ☐1000mg (>100kg) in 100mL NaCl 0.9% infused over 30 minutes.
Orencia® dose for pediatric patients < 75kg: ☐ 10mg/kg in 100mL NaCl 0.9% infused over 30 minutes.
Supply Items: Administer through infusion set containing a ***sterile, non-pyrogenic, low-protein-binding filter with pore size of 0.2 – 1.2µm.***

Dosing Regimen	Quantity
☐ **Induction:** Infuse on day 1, 15, and 29 then every 4 weeks thereafter.	3 doses (infusions)
☐ **Maintenance:** Infuse every 4 weeks.	_____ doses (infusions)

Premedication orders: _____

PRN medication orders: _____

Laboratory orders (subject to availability): _____

_____

Prescriber Signature

My signature for this prescription also confirms that the treatment(s) indicated on this referral is/are medically necessary. I authorize Home Care and its representatives to act as an agent of mine to initiate and execute the patient's insurance prior authorization process and to provide infusion-related nursing services and supplies in conjunction with the therapy prescribed above.

Signature: _____ **Date:** _____