

ORENCIA® Infusion Referral Form



University Hospitals
Home Care Services

4510 Richmond Road
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: _____ <input type="checkbox"/> M <input type="checkbox"/> F Address: _____ Phone: _____ 2 nd Phone: _____ MRN: _____ Primary Language: _____ Functional Limitations: _____						
Clinical Information	Diagnosis (Include ICD-10 Code): _____ Weight: _____ <input type="checkbox"/> lb <input type="checkbox"/> kg Height: _____ <input type="checkbox"/> in IV access: <input type="checkbox"/> PIV <input type="checkbox"/> PICC <input type="checkbox"/> Port <input type="checkbox"/> Other: _____ Patient's first dose? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, date of last dose: _____ Prior dose (in mg): _____) Allergies: _____ Latex allergy? <input type="checkbox"/> Yes <input type="checkbox"/> No Prior treatments & reason for discontinuation: _____ _____ Date of negative TB test: _____ <input type="checkbox"/> TB test pending, will fax results. Patient is HBV negative or has been treated: <input type="checkbox"/> Yes <input type="checkbox"/> No History of kidney disease: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, SCr: _____ GFR/CrCl: _____ History of heart failure: <input type="checkbox"/> Yes <input type="checkbox"/> No Referring provider's preferred site of care: <input type="checkbox"/> Home Care Infusion Center <input type="checkbox"/> Home Infusion <input type="checkbox"/> Home Care to determine site of care <small>*Site of care preference is subject to payer limitations, clinical appropriateness, and the availability of servicing providers.*</small> Additional Notes: _____ _____ _____						
Prescription Information	Orencia® dose: <input type="checkbox"/> 500mg (<60kg) <input type="checkbox"/> 750mg (60-100kg) <input type="checkbox"/> 1000mg (>100kg) in 100mL NaCl 0.9% infused over 30 minutes. Orencia® dose for pediatric patients < 75kg: <input type="checkbox"/> 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. <table border="1"><thead><tr><th>Dosing Regimen</th><th>Quantity</th></tr></thead><tbody><tr><td><input type="checkbox"/> Induction: Infuse on day 1, 15, and 29 then every 4 weeks thereafter.</td><td>3 doses (infusions)</td></tr><tr><td><input type="checkbox"/> Maintenance: Infuse every 4 weeks.</td><td>_____ doses (infusions)</td></tr></tbody></table> Premedication orders: _____ PRN medication orders: _____ Laboratory orders (subject to availability): _____ _____	Dosing Regimen	Quantity	<input type="checkbox"/> Induction: Infuse on day 1, 15, and 29 then every 4 weeks thereafter.	3 doses (infusions)	<input type="checkbox"/> Maintenance: Infuse every 4 weeks.	_____ doses (infusions)
Dosing Regimen	Quantity						
<input type="checkbox"/> Induction: Infuse on day 1, 15, and 29 then every 4 weeks thereafter.	3 doses (infusions)						
<input type="checkbox"/> Maintenance: Infuse every 4 weeks.	_____ doses (infusions)						
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: _____						

Confidentiality statement: This message is intended only for the individual or institution to which it is addressed. This may contain information, which is confidential, privileged, and/or proprietary. This information may be exempt from disclosure under applicable laws including but not limited to HIPAA. If you are not the intended recipient, please note you are strictly prohibited from distributing, copying, or disseminating this information. If you received this information in error, please notify the sender noted above and destroy all transmitted material.