ORENCIA® Infusion

OptiMed
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Phone: 877.385.0535
Fax: 877.326.2856

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

Prescriber Information

Prescriber: _____ **NPI:** _____

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

Address: _____

Patient Information

Name: _____ **DOB:** _____ ☐**M** ☐**F**

Address: _____

Phone: _____ **2nd Phone:** _____ **SSN:** _____

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 (Date of last dose: _____ Prior dose: _____) **Prior infusion reactions:** _____

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

Prior treatments & reason for discontinuation: _____

_____

Date of *negative* TB test: _____ or ☐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*: ☐OptiMed Infusion Center ☐Home Infusion* ☐OptiMed 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 IV over 30 minutes.
ORENCIA® Dose for Pediatric Patients < 75kg: ☐ 10mg/kg in 100mL NaCl 0.9% infused IV 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.***

ORENCIA® 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 OptiMed 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:** _____

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