

# Orencia® Referral Form

# IVCareOptions

PHONE: 1-800-277-7302 FAX: 1-866-374-6663

<b>Demographics Information:</b> Today's Date _____	
Patient Name: _____ DOB: _____	
Address: _____ City: _____ State: <u>GA</u> Zip: _____	
Phone #: _____ <input type="checkbox"/> Cell Alternate Phone #: _____ <input type="checkbox"/> Cell	
<b>Height:</b> _____ in/ft <b>Weight:</b> _____ lbs/kg Date weight recorded: _____ <b>Last 4 of SSN:</b> _____	
Allergies: _____ <input type="checkbox"/> NKDA	
<b>Diagnosis Information:</b>	
<input type="checkbox"/> Rheumatoid Arthritis M05.79 <input type="checkbox"/> Other Diagnosis/ICD10Code _____	
Date Infusion to Begin: _____	<b>Is this a first infusion?</b> <input type="checkbox"/> YES <input type="checkbox"/> NO
Previous Infusion Reaction: <input type="checkbox"/> YES <input type="checkbox"/> NO	<b>Date of Last Infusion:</b> _____
List Reactions: _____	<b>List of Failed Therapies:</b> _____
<b>Assessment Questions:</b> <i>Please Provide Appropriate Documentation</i>	
Diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No HTN? <input type="checkbox"/> Yes <input type="checkbox"/> No Cardiac History? <input type="checkbox"/> Yes <input type="checkbox"/> No Difficulty Breathing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Requires Oxygen? <input type="checkbox"/> Yes <input type="checkbox"/> No Confusion /Disorientation? <input type="checkbox"/> Yes <input type="checkbox"/> No Neuro History? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Date of Negative TB test:</b> _____	
<b>ORENCIA (abatacept): J0129 Patient Dose per Body Weight</b>	
<input type="checkbox"/> < 60 kg: 500 mg IV over 30 minutes at 0, 2, and 4 weeks: then every 4 weeks for _____ months	
<input type="checkbox"/> 60 to 100 kg: 750 mg IV over 30 minutes at 0, 2, and 4 weeks: then every 4 weeks for _____ months.	
<input type="checkbox"/> >100 kg: 1000 mg IV over 30 minutes at 0, 2, and 4 weeks: then every 4 weeks for _____ months.	
<b>Pre-Medications: Patient to Provide and take 30 minutes prior to infusion. Will receive 50ml NS pre- and post- infusion.</b>	
<input type="checkbox"/> Benadryl 25 MG PO x1 <input type="checkbox"/> Benadryl 50 mg PO x1	
<input type="checkbox"/> Acetaminophen 325 mg PO x1 <input type="checkbox"/> Acetaminophen 650 mg PO x1	
<input type="checkbox"/> Other Pre-medication: _____	
<b>Access:</b> <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC <b>Route:</b> <input type="checkbox"/> IV	<b>Supplies:</b> (please strike through if not required)
Catheter Care/Flush: To gain access, use for any ordered pre-medications, and/or PRN to maintain access and patency	Administration Supplies (A4222) – 1 per infusion
PIV – NS 5ml: Qty 3	Catheter Care Supplies (A4221) – 1 per week
PORT – NS 10ml: Qty 3, Heparin 5mL 100units/mL x 1 per infusion.	Infusion Pump (E0781)
PICC – NS 10ml: Qty 3, Heparin 5mL 10units/mL x 1 per infusion	Nursing services to administer
	<b>Administration through an in-line 0.2- to 1.2-micron, sterile, nonpyrogenic, low-protein binding filter is required.</b>
<i>For insurance compliance, the prescribing physician or PA must sign, no stamps or nurse/NP signatures</i>	
Physician/PA signature: _____	
NPI # _____ Phone Number _____	
Office Address: _____ City: _____ St _____ Zip: _____	
Printed Name: _____ Contact Name: _____	
<b>Please fax this form to our Intake Department along with a copy of Patient's Insurance Card, Demographic information, H &amp; P, Office Visit notes - including supporting documentation for failed therapies, and Up to Date Medication List.</b>	