

Orencia® Referral Form

IVCareOptions

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

Demographics Information: Today's Date _____	
Patient Name: _____ DOB: _____	
Address: _____ City: _____ State: <u>GA</u> Zip: _____	
Phone #: _____ <input type="checkbox"/> Cell Alternate Phone #: _____ <input type="checkbox"/> Cell	
Height: _____ in/ft Weight: _____ lbs/kg Date weight recorded: _____ Last 4 of SSN: _____	
Allergies: _____ <input type="checkbox"/> NKDA	
Diagnosis Information:	
<input type="checkbox"/> Rheumatoid Arthritis M05.79 <input type="checkbox"/> Other Diagnosis/ICD10Code _____	
Date Infusion to Begin: _____	Is this a first infusion? <input type="checkbox"/> YES <input type="checkbox"/> NO
Previous Infusion Reaction: <input type="checkbox"/> YES <input type="checkbox"/> NO	Date of Last Infusion: _____
List Reactions: _____	List of Failed Therapies: _____
Assessment Questions: <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	
Date of Negative TB test: _____	
ORENCIA (abatacept): J0129 Patient Dose per Body Weight	
<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.	
Pre-Medications: Patient to Provide and take 30 minutes prior to infusion. Will receive 50ml NS pre- and post- infusion.	
<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: _____	
Access: <input type="checkbox"/> PIV <input type="checkbox"/> PORT <input type="checkbox"/> PICC Route: <input type="checkbox"/> IV	Supplies: (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 10	Catheter Care Supplies (A4221) – 1 per week
PORT – NS 10ml: Qty 10, Heparin 5mL 100units/mL x 1 per infusion.	Infusion Pump (E0781)
PICC – NS 10ml: Qty 10, Heparin 5mL 10units/mL x 1 per infusion	Nursing services to administer
	Administration through an in-line 0.2- to 1.2-micron, sterile, nonpyrogenic, low-protein binding filter is required.
<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 <u>GA</u> Zip: _____
Printed Name: _____	Contact Name: _____
Please fax this form to our Intake Department along with a copy of Patient's Insurance Card, Demographic information, H & P, Office Visit notes - including supporting documentation for failed therapies, and Up to Date Medication List.	
05/21TSP	