ORENCIA® Infusion

OptiMed
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6480 Technology Ave., Suite A | Kalamazoo, MI 49009

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: ____

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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): ____

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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 administrative nursing services and supplies in conjunction with the therapy prescribed above.

Signature: ______________________________ **Date:** ______________

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