PRIMERA SPECIALTY INFUSION

ORENCIA REFERRAL FORM

Patient Name _____
Date of Birth _____
Gender at Birth ◯Male ◯Female
Address _____
City, State, Zip _____
Phone _____
Email _____

Primary Insurance _____
Secondary Insurance _____

Prescriber Name _____
NPI # _____ DEA # _____
State Lic # _____ UPI # _____

Practice Name _____
Address _____
City, State, Zip _____

Office Contact _____
Office Contact Phone _____
Office Contact Email _____

CLINICAL INFORMATION

Primary Diagnosis/ICD10 _____
Diagnosis Date _____

Prior Therapies/Duration of Use _____
Access Type ☐ Peripheral IV ☐ PICC ☐ Implant Port ☐ Broviac/Hickman

Current Therapy _____
Current Directions _____
Weight _____ Height _____ Allergies _____
Last Dose _____ Next Dose _____

Negative HBV ☐ Yes ☐ No Date of Test: _____
Negative TB ☐ Yes ☐ No Date of Test: _____

Antiviral prophylactic treatment for Epstein-Barr virus (EBV) reactivation ☐ Yes ☐ No
Prophylactic antivirals for CMV infection/reactivation during treatment and for 6 months following HSCT ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Medication	**ORENCIA®**
Directions	☐ **Moderate to Severe Rheumatoid Arthritis (RA)** ☐ **Active Psoriatic Arthritis (PSA)** **Dose:** ☐<60 kg (132 lbs): **500 mg IV** (2 vials) ☐ 60-100 kg (132-220 lbs): **750 mg IV** (3 vials) ☐ >100 kg (220 lbs): **1,000 mg IV** (4 vials) Total dose: _____**mg** Quantity:**1 year** Refills: **0** Directions: _____**mg intravenously on day 1, day 15, day 29 then every 4 weeks** Administration Rate: ☑ Per Prescribing Information, as tolerated ☐ Other: _____ ☐ **Moderate to Severe Polyarticular Juvenile Idiopathic Arthritis (pJIA)** **Dose:** ☐ <75 kg (<165 lbs): **10 mg/kg IV** ☐ 75 kg to 100 kg (165-220 lbs): **750 mg IV** (3 vials) ☐ >100 kg (>220 lbs): **1,000 mg IV** (4 vials) Total dose: _____**mg** Quantity:**1 year** Refills: **0** Directions: _____**mg intravenously on day 1, day 15, day 29 then every 4 weeks** Administration Rate: ☑ Per Prescribing Information, as tolerated ☐ Other: _____ ☐ **Prophylaxis of aGVHD in adults** **Dose:** 10 mg/kg (Maximum dose: 1,000 mg) Total dose: ____ **mg** Quantity: **4 doses** Refills:**0** Directions: **For patients 6 years and older, administer ORENCIA 10 mg/kg (maximum dose of 1000 mg) as an intravenous infusion over 60 minutes on the day before transplantation (Day -1), followed by administration on Days 5, 14, and 28 after transplantation.** Administration Rate: ☑ Per Prescribing Information, as tolerated ☐ Other: _____ ☐ **Prophylaxis of aGVHD in adults and pediatric patients** **Dose**: Day -1 Dose: _____ **mg** Days 5, 14 & 28 Dose: _____ **mg** Total dose:____ **mg** Quantity: **4 doses** Refills:**0** Directions: **For patients 2 to less than 6 years old, administer ORENCIA 15 mg/kg as an intravenous infusion over 60 minutes on the day before transplantation (Day -1), followed by 12 mg/kg as an intravenous infusion over 60 minutes on Days 5, 14, and 28 after transplantation** Administration Rate: ☑ Per Prescribing Information, as tolerated ☐ Other: _____
Pre-Medications	☐ Acetaminophen 650mg 30 minutes prior to infusion PO ☐ Solu-Cortef _____mg slow IVP ☐ Diphenhydramine 25mg 30 minutes prior to infusion ☐ PO ☐ IV ☐ Solu-Medrol _____mg slow IVP Administered: ☐ Pre ☐ Halfway ☐ Upon Completion
Anaphylaxis Orders & Medications	Orders: 1. Stop Infusion 2. Call 911 and prescribing physician 3. Administer medications per protocol Diphenhydramine 50mg/mL slow IVP/IM Administer 12.5mg (wt.<15kg), Administer 25mg (wt.15-30kg) Administer 50mg (wt. > 30kg) Qty 1 Epinephrine 1mg/mL– Administer___ mg (wt. < 15kg) IM, Administer 0.15mg (wt. 15-30kg) IM, Administer 0.3mg (wt. > 30kg) IM Qty: 2 Sodium Chloride 0.9% – Administer 250mL IV at KVO (20ml/hr)
Flushing Protocol	☐ Sodium Chloride 0.9% 5-10mL pre and post medications ☐ Heparin_____Units/mL _____mL as needed
Pump & Supplies	☑ Pump and supplies as needed for administration and appropriate disposal of infusion materials
Skilled Nursing Visits	☑ As needed for IV access, administration and appropriate clinical monitoring

In order for brand name product to be dispensed when generic is available, prescriber must handwrite "Dispense As Written" to prohibit substitution. By signing below, I certify that the above therapy is medically necessary and that the provided medical information is accurate to the best of my knowledge. I authorize Primera Specialty Infusion to act as an agent to initiate and execute the insurance prior authorization process for this prescription and any future fills of the same prescription for patient listed above. I understand that I can revoke this designation by providing notice to Primera Specialty Infusion. Mail 795 Primera Blvd, Ste 1011, Lake Mary, FL 32746 Phone (689) 303-3338 Fax (689) 303-3240

Prescriber Signature _____ **Date** _____