

Treatment Location: _____

PROVIDERS: Please include the following to expedite the order:

Patient Demographics, Most Recent Office Visit Note, Insurance Information, Screening for latent TB Infection and Viral Hepatitis

PATIENT INFORMATIONReferral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ Patient Phone: _____ DOB: _____

ICD-10 code (required): M05.____ M06.____ M08.____ L40.____ ICD Description: _____

Allergies: _____ Weight (lbs/kg): _____ Height: _____

Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____**PROVIDER INFORMATION**

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip: _____

NURSING

- Center will use Hypersensitivity protocol established by Infusion for Health and PI
- TB Status and Date (list results & attached clinicals): _____
- Hepatitis B Status and Date (list results & attach clinicals): _____
- List of tried and failed medications related to diagnosis: _____

LABORATORY ORDERS

- CBC at each dose every _____
- CMP at each dose every _____
- Other: _____ Frequency: _____
- Please check this box if you DO NOT authorize Infusion for Health to order and draw labs indicated for clinical clearance and/or insurance authorization prior to treatment.

PRE-MEDICATION ORDERS

Pre-medications not usually indicated.

- Diphenhydramine 25mg / 50mg PO / IV
 - Acetaminophen 325mg / 500mg / 650mg PO
 - Other: _____
- Dose: _____ Route: _____ Frequency: _____

THERAPY ADMINISTRATION

- Orencia Intravenous Infusion
 - Dose: <60kg - Dose: 500mg
 - 60-100kg - Dose: 750mg
 - > 100kg - Dose: 1000mg
 - Other: _____
- Frequency:
 - Induction: Week 0, 2, and 4 then
 - Every 4 Weeks
- Refills: Zero / for 12 months / _____
(if not indicated order will expire one year from date signed)

To ensure that a brand name product is dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form. If not indicated, I4H is authorized to administer a generic or biosimilar.

Provider Name (Print) _____ Provider Signature _____ Date _____

- Please check this box if you DO NOT authorize Infusion for Health to complete a Peer to Peer on behalf of the prescribing provider for an insurance company that denies authorization for treatment.