**TwelveStone Health Partners**

**Fax Referral To:**

**(800) 223-4063**

Direct Phone: (615) 278-3350

Toll Free: (844) 893-0012

TwelveStone HEALTH PARTNERS™

## ORENCIA ORDER FORM

| | |
|---|---|
| Date: ______________________________ | ICD-10 Code: ____________________ |
| Patient Name: ______________________________ | Allergies: ____________________ |
| Date of Birth: ______________________________ | Weight: ________lbs OR ________kg |

| Therapy Status | Provider Information |
|---|---|
| ☐ New Start<br>☐ Continuing Therapy:<br>Last Dose: ____________________ | Ordering Provider: ______________________________<br>Provider NPI: ______________________________<br>Provider Phone: ______________________________<br>Provider Fax: ______________________________<br>Provider Address: ______________________________ |

## MEDICATION ORDER

| | | | |
|---|---|---|---|
| ☐ Orencia | ☐ Infuse Orencia per weight-based dosing guide lines below IV at weeks 0, 2 and 4 followed by every 4 weeks thereafter per protocol.<br>☐ Infuse Orencia per weight-based dosing guide lines below IV every 4 weeks per protocol.<br>✓ *Weight-Based Dosing Guidelines:*<br>*Less than 60kg: 500mg dose*<br>*60kg to 100 kg: 750mg dose*<br>*More than 100kg: 1,000mg dose* | Refills x one year from date of signature unless indicated below.<br>☐ ________Refills | ***Please include the following lab results required for infusion. If no results are available, the following labs will be drawn prior to first infusion:***<br>✓Hepatitis B Surface Antigen.<br>✓Hebatitis B Core Antibody.<br>✓Negative TB Quantiferon Gold, TB Skin Test OR Chest X-Ray within the last 12 months. |

## PRE-MEDICATIONS

***Oral***

- ☐ Acetaminophen: ______325mg ______500mg ______650mg
- ☐ Loratadine: 10mg
- ☐ Cetirizine: 10mg
- ☐ Diphenhydramine: ______ 25mg ______ 50mg
- ☐ Famotidine: ______ 20mg ______ 40mg
- ☐ Ibuprofen: ______ 200mg ______ 400mg ______600mg
- ☐ Ondansetron: ______ 4mg ______ 8mg
- ☐ Other: ______________________________

***IV***

- ☐ Dexamethasone: ______4mg ______ 8mg
- ☐ Diphenhydramine: ______25mg ______50mg
- ☐ Famotidine: ______20mg ______40mg
- ☐ Methylprednisolone: 125mg
- ☐ Hydrocortisone: 100mg
- ☐ Ondansetron: ______4mg ______8mg
- ☐ Other: ______________________________

## LAB ORDERS (please indicate any labs to be drawn and frequency)

**Surveillance lab ordering and monitoring is the responsibility of the prescriber**

## OTHER REQUIRED DOCUMENTATION

(Please fax this signed order form, along with the following documents to 800-223-4063)

- History & Physical, Last Office Visit Note
- Patient Demographics and Insurance Information
- Medication List
- Recent Lab Work

By signing below, I certify that the above therapy is medically necessary. **Prescriber's Signature (SIGN BELOW)**

| Dispense as Written: | Substitution Allowed: |
|---|---|
| ______________________ Prescriber Name ____________ Date | ______________________ Prescriber Name ____________ Date |

V 12.20.22