

## ORENCIA REFERRAL FORM

### PATIENT DEMOGRAPHICS:

PATIENT NAME:	PATIENT'S CONTACT #:	
DATE OF REFERRAL:	ADDRESS:	
DATE OF BIRTH:	CITY, STATE, ZIP:	
FOR COPAY ASSISTANCE, PLEASE PROVIDE LAST 4 OF SSN:		
HEIGHT: _____ FEET _____ INCHES	GENDER: FEMALE	MALE
WEIGHT: _____ LB or _____ KG	ALLERGIES: SEE LIST	NKDA

### PRIMARY DIAGNOSIS:

M05.7 - Rheumatoid arthritis with rheumatoid factor without organ or systems involvement	M05.8 - Other rheumatoid arthritis with rheumatoid factor	
M06.0 - Rheumatoid arthritis without rheumatoid factor	M08.0 - Unspecified juvenile rheumatoid arthritis	
M08.2 - Juvenile rheumatoid arthritis with systemic onset	M08.4 - Pauciarticular juvenile rheumatoid arthritis	L40 - Psoriasis
L40.50 - Arthropathic psoriasis, unspecified	L40.53 - Psoriatic spondylitis	L40.59 - Other psoriatic arthropathy

### REQUIRED DOCUMENTATION: Please provide a copy of the following documents.

1. INSURANCE CARD (Front & Back)  
  2. PATIENT DEMOGRAPHICS  
  3. MOST RECENT LABS  
  4. MEDICATION LIST  
  5. H & P  
 6. TRIED/FAILED THERAPIES  
  7. NEGATIVE TB TEST RESULTS  
  8. HEPATITIS PANEL

### PRIMARY MEDICATION ORDER:

### PRN & PREMEDICATIONS:

<u>Intravenous Use for Adult RA or PsA:</u> Less than 60 kg: Orenzia 500 mg IV at week 0, 2, 4, and every 4 weeks thereafter. 60 kg to 100 kg: Orenzia 750 mg IV at week 0, 2, 4, and every 4 weeks thereafter. More than 100 kg: Orenzia 1000 mg IV at week 0, 2, 4, and every 4 weeks thereafter. <u>Subcutaneous Use for Adult RA:</u> Orenzia 125 mg subcutaneous injection once weekly (within 1 day of the IV infusion if IV loading dose is given). <u>Optional IV Loading Dose for Subcutaneous Use with Adult RA:</u> Less than 60 kg: Orenzia 500 mg IV once. 60 kg to 100 kg: Orenzia 750 mg IV once. More than 100 kg: Orenzia 1000 mg IV once. <u>Subcutaneous Use for Adult PsA:</u> Orenzia 125 mg subcutaneous injection once weekly (with no IV loading dose). FIRST DOSE:      Y      N <input checked="" type="checkbox"/> Refill x12 months unless otherwise noted.	MEDICATIONS	30 minutes prior to every infusion	PRN
	Acetaminophen 650 mg PO		PRN every ___ hour for mild or moderate infusion reaction.
	Diphenhydramine 25 mg PO		PRN every ___ hour for mild or moderate infusion reaction.
	Diphenhydramine 25 mg IV		PRN every ___ hour for mild or moderate infusion reaction.
	Methylprednisolone 125 mg IV		PRN every ___ hour for mild or moderate infusion reaction.
	Other: _____		PRN every ___ hour for mild or moderate infusion reaction.

### LINE USE/CARE ORDERS:

### ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> START PIV/ACCESS CVC <input checked="" type="checkbox"/> FLUSH DEVICE PER FLEXCARE INFUSION POLICY & PROCEDURE (SEE REVERSE SIDE) OTHER FLUSH ORDERS: (please fax other reaction orders if checking this box)	<input checked="" type="checkbox"/> ADMINISTER ACUTE INFUSION AND ANAPHYLAXIS MEDICATIONS PER FLEXCARE INFUSION POLICY AND PROCEDURE (See Reverse Side) OTHER: (please fax other reaction orders if checking this box)
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### PRESCRIBER INFORMATION: Please check preferred form of communication.

PROVIDER NAME:	PHONE:
OFFICE CONTACT:	<input type="checkbox"/> FAX:
ADDRESS:	<input type="checkbox"/> EMAIL:
CITY, STATE, ZIP:	NPI:

➔ (GENERIC SUBSTITUTION PERMITTED)

PROVIDER SIGNATURE:

DATE:

➔ (DISPENSE AS WRITTEN)

PROVIDER SIGNATURE:

DATE:

# GI REFERRAL FORM

## FLEXCARE INFUSION CENTER'S ACUTE & ANAPHYLAXIS MEDICATION PROTOCOL:

*\*This table does not reflect non-medicinal interventions that are part of FlexCare's protocol, such as slowing or stopping the infusion and physician/911 notification.*

	MILD INFUSION REACTION	MODERATE INFUSION REACTION	SEVERE INFUSION REACTION/ANAPHYLAXIS
<b>SYMPTOM CLASSIFICATION</b>	<ul style="list-style-type: none"> <li>Flushing</li> <li>Dizziness</li> <li>Headache</li> <li>Apprehension</li> <li>Diaphoresis</li> <li>Palpitations</li> <li>Nausea / Vomiting</li> <li>Pruitis</li> </ul>	<ul style="list-style-type: none"> <li>Chest Tightness</li> <li>Shortness of Breath</li> <li>Hypo/hypertension (&gt;20 mmHg Change in Systolic BP from Baseline)</li> <li>Increased Temperature (&gt;2 Degrees Fahrenheit)</li> <li>Urticaria</li> </ul>	<ul style="list-style-type: none"> <li>Hypo/hypertension (&gt;40 mmHg Change in Systolic BP from Baseline).</li> <li>Increase Temperature (&gt;2 Degrees Fahrenheit) with Rigors</li> <li>Shortness of Breath with Wheezing</li> <li>Laryngeal Edema</li> <li>Chest Pain</li> <li>Hypoxemia</li> </ul>
<b>TREATMENT PROTOCOL FOR ADULTS &gt;66LBS</b>	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500 mL at 125mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 50 mg IV or IM Inject epinephrine 0.3mg/0.3 mL IM into the midanterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl 1000mL bolus for an incomplete response to IM epinephrine. May repeat x1.
<b>TREATMENT PROTOCOL FOR CHILDREN 33LBS - 66 LBS</b>	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Administer PRN medications per Physician order	<input checked="" type="checkbox"/> Apply oxygen via ambu bag or high flow nasal canula, if vomiting. <input checked="" type="checkbox"/> Administer 0.9% NaCl 500mL at 75mL/hr to maintain IV access. <input checked="" type="checkbox"/> Administer diphenhydramine 1-2 mg/kg IM or slow IVP not to exceed 25mg/min <input checked="" type="checkbox"/> Inject epinephrine 0.15mg/0.15 mL IM into the mid-anterolateral aspect of the thigh; repeat in 5-15 minutes if needed. <input checked="" type="checkbox"/> Administer 0.9% NaCl bolus 20mL/kg for an incomplete response to IM epinephrine. May repeat x1.

**FOR CHILDREN < 33 LBS FLEXCARE INFUSION UTILIZES THE REACTION ORDERS OBTAINED BY THE REFERRING PHYSICIAN.**

## FLUSHING PROTOCOLS

		FLUSHING PROTOCOL Normal Saline*		LOCKING PROTOCOL Heparin Sodium	
		0.9% Sodium Chloride		10 Units/mL	100 Units/mL
PATIENT CLASSIFICATION	LINE TYPE	PRE-ADMIN	POST ADMIN	POST LAB DRAW	POST NS FLUSH*
<b>ADULT &gt; 66 LBS</b>	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	10 mL	10 mL	5 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	10 mL	10 mL	5 mL
	Tunneled & non-Tunneled Catheters	5 mL	10 mL	10 mL	5 mL
<b>PEDIATRIC 33 LBS - 66 LBS</b>	Peripheral IV Catheter	3 mL	3 mL		3 mL
	Midline	3 mL	3 mL		3 mL
	Implanted Port	5 mL	5 mL	10 mL	3 mL
	Peripherally Inserted Central Catheters (PICC)	5 mL	5 mL	10 mL	3 mL
	Tunneled & non-Tunneled Catheters	5 mL	5 mL	10 mL	3 mL

**FOR CHILDREN <33 LBS, FLEXCARE INFUSION UTILIZES THE FLUSHING ORDERS OBTAINED BY THE REFERRING PHYSICIAN.**

\*0.9% NS will be substituted with Dextrose 5% or alternative only when indicated due to medication incompatibility with NS.