City of Hope | ORANGE COUNTY

HOPE INFUSIONS REFERRAL ORDER FORM

Please fax to: (626) 737-1307

☐ **Newport Beach Fashion Island:**	1601 Avocado Ave., Newport Beach, CA 92660	PH: (949) 763-2204
☐ **Newport Beach Lido:**	351 Hospital Rd., #610, Newport Beach, CA 92663	PH: (949) 999-1400
☐ **Huntington Beach:**	19671 Beach Blvd., #315, Huntington Beach, CA 92648	PH: (714) 252-9415
☐ **Irvine Sand Canyon:**	16300 Sand Canyon Ave., #207, 208, 209, Irvine, CA 92618	PH: (949) 333-7580

Patient Name: _____ **DOB:** ___/___/_____ **Ht:** _____ **Wt:** _____

Allergies: ☐ No known allergies

☐ **Allergic to:** _____

Reaction: ☐ Anaphylaxis ☐ Edema ☐ Hives ☐ Pruritis ☐ Rash ☐ Unknown ☐ Other: _____

Severity: ☐ Severe ☐ Moderate ☐ Mild

Diagnosis: _____ **ICD-10 code:** _____

Premedication(s): ☐ None

_____

_____

Medication:

_____

_____

Repeat every _____ (frequency) for a total of _____ doses.

(Note: A new order will be required annually for ongoing treatment)

Labs (include frequency): ☐ None

_____

Please include:

☐ Patient demographics, contact, and insurance information

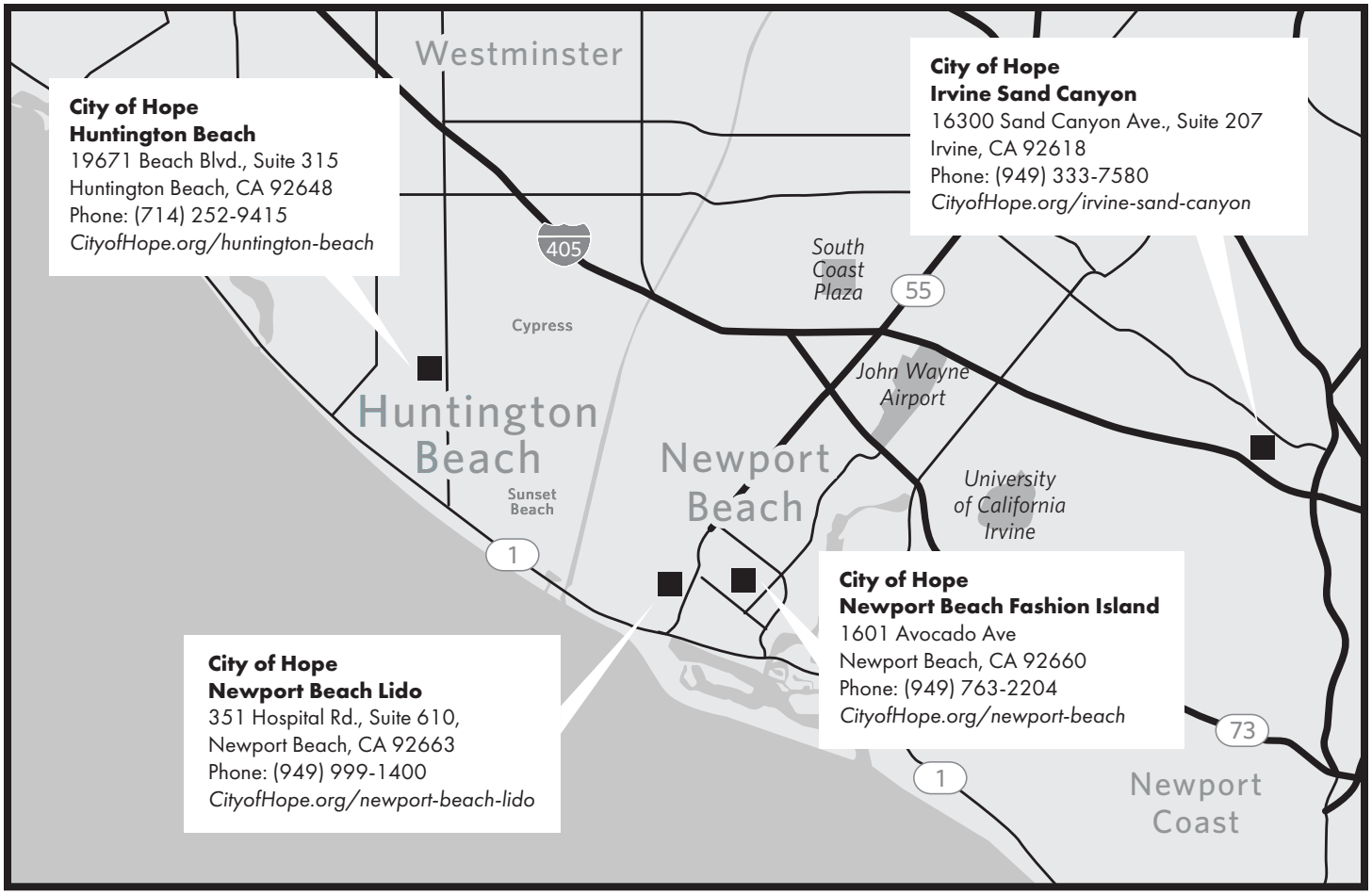
☐ Pertinent medical records and test results

☐ Treatment authorization information if already obtained

Certification: As the referring physician, I certify that the patient has been informed of: (a) the risks and benefits of the treatment I am ordering; (b) adverse reactions that may reasonably be expected to occur in connection with the treatment; and (c) alternative options for treatment which are medically viable. I further certify that the patient has been encouraged to ask questions and that all questions were answered. If applicable, I confirm the patient's pregnancy status is not contraindicated with prescribed treatment and appropriate consultation has occurred. Since I intend to remain primarily responsible for the patient's medical care plan, once the treatment in this referral order is complete, I will provide continuing post-treatment care to the patient.

PRINTED NAME OF PHYSICIAN	SIGNATURE/TITLE	DATE (MM/DD/YY)
OFFICE CONTACT NAME		
CA LICENSE #	PHONE	FAX

City of Hope Medical Foundation **Non-Oncology Referral Order Form**	This design is approved to go into FormFast Production. Form Requestor: _____ Form Owner: _____



HOPE INFUSIONS

City of Hope Orange County's expertise in infusion therapy extends beyond cancer-related drugs. We also administer non-oncology medications, all with the same knowledgeable staff and compassionate patient care.

Benlysta®

Cerezyme® or VPIRV™ for Gaucher's Disease

Cimzia®

Cinqair® (Reslizumab) for Asthma

Evenity® (romosozumab)

Evkeeza™ (Evinacumab)

Factor VIII for Hemophilia A

Fasenra™ (benralizumab)

HyQvia

Ilumya™ (tildrakizumab)

Intravenous Immune Globulin (IVIG) (Gammagard®, Octagam®)

Intravenous Iron (Injectafer®, INFeD®, Ferrlecit®, Feraheme®)

Intravenous Reclast®, zoledronic acid for Osteoporosis

Krystexxa®

Lemtrada® (Alemtuzumab) for Multiple Sclerosis

Lupron®

Nucala® (mepolizumab)

Nulojix® (Belatacept) for kidney transplant patients

Ocrevus™ (ocrelizumab) for Multiple Sclerosis

Onpattro™ (patisiran)

Prolia®

Radisav™ (edaravone) for Amyotrophic Lateral Sclerosis

Remicade®, Inflectra®, Renflexis®, Entyvio™, Orencia®, Actemra®, Stelara®

Rituximab

Saphnelo™

Simponi Aria®

Solu-Medrol

Tepezza™ (Teprotumumab-trbw) for Thyroid Eye Disease

Tremfya®

Tysabri®

Uplizna®

XOLAIR® (omalizumab)

Other therapies may be given upon request

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