ORENCIA
(abatacept)

FAX to + 1 208.963.3245 or
Email to intake@infusionspecialists.org
To ensure processing of your order, please complete all fields.

INFUSION SPECIALISTS

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- Medication List
- History & Physical
- Negative TB Results
- Patient Demographics
- Hepatitis Panel
- Most Recent Labs
- MRI Results

PRIMARY DIAGNOSIS

☐ M05.79 Rheumatoid arthritis with rheumatoid factor, multiple sites without organ or systems involvement
☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified
☐ M06.00 Rheumatoid arthritis without rheumatoid factor, unspecified site
☐ M06.89 Other specified rheumatoid arthritis, multiple sites
☐ M06.9 Rheumatoid arthritis, unspecified
☐ Other:_____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Orencia
☐ Provider Prescribed: _____

PRIMARY MEDICATION ORDER

☐ Weight <60kg: Orencia 500mg IV at week 0, 2, 4, and every 4 weeks thereafter
☐ Weight 60kg-100kg: Orencia 750mg IV at week 0, 2, 4, and every 4 weeks thereafter
☐ Weight >100kg: Orencia 1000mg IV at week 0, 2, 4, and every 4 weeks thereafter
☐ Orencia_____mg IV every_____weeks
☐ Other: _____

First Dose: ☐Y ☐N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Infusion Specialists' protocol (See infusionspecialist.org for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Infusion Specialists' protocol
(See infusionspecialist.org for detailed policy)
☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____