LIFE
SPECIALTY SOLUTIONS

# ORENCIA
(abatacept)

## PATIENT INFORMATION

PATIENT NAME: ______ PHONE #: ______

ADDRESS: ______ CITY, STATE, ZIP: ______

DATE OF BIRTH: ______ EMAIL: ______

ALLERGIES: ☐ SEE LIST ☐ NKDA WEIGHT: ☐ LB OR ☐ KG

## REQUIRED DOCUMENTATION

1. Insurance Card 2. History & Physical 3. Patient Demographics 4. Medication List 5. Most Recent Labs
6. MRI Results 7. Negative TB Results 8. Hepatitis Panel

## 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 ______

## LABS ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: ______

## PRE-MEDICATIONS

☑ Per infusion clinic protocol: There are 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?: ☐ Yes ☐ No ☑ Refill x12 months unless otherwise noted.

## LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC
☑ Flush device per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
☐ Other Flush Orders: Please send other line care orders if checking this box

## ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Real Medix - Real Infusions protocol (See realinfusions.com for detailed policy)
☐ Other: (Please send other reaction orders if checking this box)

## PRESCRIBER INFORMATION

PROVIDER NAME: ______ PHONE: ______

OFFICE CONTACT: ______ FAX: ______

ADDRESS: ______ EMAIL: ______

CITY, STATE, ZIP: ______ NPI AND LICENSE: ______

✖ ______
PROVIDER SIGNATURE

______
DATE