



**PATIENT DEMOGRAPHICS**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_  
 Allergies: \_\_\_\_\_  NKDA Weight: \_\_\_\_\_  lbs  kg Height: \_\_\_\_\_  in  cm  
**Patient Status:**  New to Therapy  Dose or Frequency Change  Order Renewal

**INSURANCE INFORMATION: Please attach copy of insurance card (front and back).**

**DIAGNOSIS\***

**\*ICD 10 Code  
Required**

- Rheumatoid Arthritis (M05.70-M05.9, M06.00-M06.09, M06.9), ICD10 \_\_\_\_\_
- Juvenile Idiopathic Arthritis (M08.00-M08.99), ICD10 \_\_\_\_\_
- Psoriatic Arthritis (L40.50.-L40.59), ICD10 \_\_\_\_\_
- Other: \_\_\_\_\_, ICD10 \_\_\_\_\_

**INFUSION ORDERS**

MEDICATION	DOSE	DIRECTIONS/DURATION
Orencia® (abatacept)	<input type="checkbox"/> <60kg: 500mg <input type="checkbox"/> 60-100kg: 750mg <input type="checkbox"/> >100kg: 1000mg	<input type="checkbox"/> <b>INITIAL:</b> Infuse IV over 30 minutes at Weeks 0, 2, 4, then every 4 weeks x 1 year <input type="checkbox"/> <b>MAINTENANCE:</b> Infuse IV over 30 minutes every 4 weeks x 1 year

**Is patient currently receiving therapy above from another facility?**

If yes, Facility Name: \_\_\_\_\_

Yes  No

Date of last treatment: \_\_\_\_\_ Date of next treatment: \_\_\_\_\_

**PRE-MEDICATION ORDERS**

- No premeds ordered at this time
- Acetaminophen 650mg PO  Diphenhydramine 25mg PO
- Methylprednisolone 40mg IVP -OR-  Hydrocortisone 100mg IVP
- Other: \_\_\_\_\_

**LAB ORDERS**

- Labs to be drawn by:**  Infusion Center  Referring Physician
- No labs ordered at this time
- CBC q \_\_\_\_\_  CMP q \_\_\_\_\_  CRP q \_\_\_\_\_
- ESR q \_\_\_\_\_  LFTs q \_\_\_\_\_  Other: \_\_\_\_\_

**REFERRING PHYSICIAN INFORMATION**

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Physician Name: \_\_\_\_\_ Provider NPI: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Address: \_\_\_\_\_ City/ST/Zip: \_\_\_\_\_  
 Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_  
 Email Where Follow Up Documentation Should Be Sent: \_\_\_\_\_

**REQUIRED CLINICAL DOCUMENTATION**

**Please attach medical records: Initial H&P, current MD progress notes, medication list, and labs/test results to support diagnosis.**

See Attached Medical Records

**LAB AND TEST RESULTS (required)**

- TB screening (submit results from within 12 months to start therapy and annually to continue therapy)
  - Annual TB screening to be done by:  Infusion Center  Referring Physician
- Hepatitis B Screening (submit results to start therapy)

**PRIOR FAILED THERAPIES (including DMARDs, immunosuppressants, and biologics)**

Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
 Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
 Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
 Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_  
 Medication Failed: \_\_\_\_\_ Dates of Treatment: \_\_\_\_\_ Reason for D/C: \_\_\_\_\_