1935 W. State Street STE 103
Garland, TX 75042
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# ORENCIA (Abatacept) IV REFERRAL FORM

| PATIENT INFORMATION | |
|---|---|
| Name: | DOB: |
| Allergies: | Patient Weight: _____________kg ; ______________lbs |

| DIAGNOSIS AND ICD 10 CODE | | | |
|---|---|---|---|
| ☐ Rheumatoid Arthritis | ICD 10 Code: _____________ | ☐ Psoriatic Arthritis | ICD 10 Code: _____________ |
| ☐ Systemic Juvenile Idiopathic Arthritis (SJIA) | ICD 10 Code: _____________ | ☐ GVHD | ICD 10 Code: _____________ |
| | | ☐ Other:____________ | |

| REQUIRED DOCUMENTATION | |
|---|---|
| ☐ This signed order form by the provider | ☐ **Tuberculosis QFT test or a neg CRX- ANNUAL** |
| ☐ Patient demographics and Insurance Card | ☐ **Hepatitis B antigen** |
| ☐ Clinical/Progress notes | ☐ First Dose -or- ☐ Last given dose:________________ |
| List Tried & Failed Therapies, including duration of treatment:<br>1)<br>2)<br>3) | PA Guidance: Documented failed trial of a DMARD, NSAID, steroids like MTX, 6-MP, leflunomide. Documented failed trial of a biologic like Humira, Enbrel, or Stelara. |

| MEDICATION ORDERS | |
|---|---|
| Dosing (RA and SJIA >75kg) | ☐ Orencia 500mg (Weight < 60kg) IV at Week 0, 2, 4 then every 4 weeks<br>☐ Orencia 750mg (Weight 60-100kg) IV at Week 0, 2, 4 then every 4 weeks<br>☐ Orencia 1000mg (Weight >100kg) IV at Week 0, 2, 4 then every 4 weeks<br>☐ Maintenance: Orencia _________ mg IV every 4 weeks |
| SJIA Dosing (<75kg) | ☐ Orencia 10mg/kg IV at Week 0, 2, 4 then every 4 weeks (Max dose= 1000mg)<br>☐ Maintenance: Orencia 10mg/kg IV every 4 weeks (Max dose = 1000mg) |
| Infusion Orders | ■ Nurse to start, pause, or discontinue peripheral or central venus access device PRN<br>■ Flush IV line with 10-20ml saline before and after each medication dose or as needed<br>■ Flush PORT or Central Line with 500u/5ml Heparin as FINAL flush or as needed<br>■ Dispense DME pump with all necessary supplies for home infusion |
| Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 1L 0.9% NS) | |
| Refills: | ■ X 1 year ■ _____ doses |

| PRESCRIBER INFORMATION | | |
|---|---|---|
| Prescriber Name: | | |
| Office Phone: | Office Fax: | Office Email: |
| Prescriber Signature: | | Date: |

By signing, I authorize Texas Infusion to act as an agent to initiate and execute the insurance authorization process for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time in writing via email to pharmacy@texasinfusion.com

**PLEASE FAX SIGNED FORM TO 972-787-1492**

UPDATED: 1-2-2023