



1935 W. State Street STE 103
 Garland, TX 75042
 Ph: 972-372-9787
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ORENCIA (Abatacept) IV ORDER FORM

PATIENT INFORMATION

Name:	DOB:
Allergies:	Weight: _____ kg ; Height: _____ lbs

DIAGNOSIS AND ICD 10 CODE

<input type="checkbox"/> Rheumatoid Arthritis	ICD 10 Code: _____	<input type="checkbox"/> Psoriatic Arthritis	ICD 10 Code: _____
<input type="checkbox"/> Systemic Juvenile Idiopathic Arthritis (SJIA)	ICD 10 Code: _____	<input type="checkbox"/> GVHD	ICD 10 Code: _____
		<input type="checkbox"/> Other: _____	

REQUIRED DOCUMENTATION

<input type="checkbox"/> This signed order form by the provider <input type="checkbox"/> Patient demographics and Insurance Card <input type="checkbox"/> Clinical/Progress notes	<input type="checkbox"/> Tuberculosis QFT test or a neg CRX- ANNUAL <input type="checkbox"/> Hepatitis B antigen <input type="checkbox"/> First Dose -or- <input type="checkbox"/> Last given dose: _____
List Tried & Failed Therapies, including duration of treatment: 1) _____ 2) _____ 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)	<input type="checkbox"/> Orencia 500mg (Weight < 60kg) IV at Week 0, 2, 4 then every 4 weeks <input type="checkbox"/> Orencia 750mg (Weight 60-100kg) IV at Week 0, 2, 4 then every 4 weeks <input type="checkbox"/> Orencia 1000mg (Weight >100kg) IV at Week 0, 2, 4 then every 4 weeks <input type="checkbox"/> Maintenance: Orencia _____ mg IV every 4 weeks
SJIA Dosing (<75kg)	<input type="checkbox"/> Orencia 10mg/kg IV at Week 0, 2, 4 then every 4 weeks (Max dose= 1000mg) <input type="checkbox"/> Maintenance: Orencia 10mg/kg IV every 4 weeks (Max dose = 1000mg)
Infusion Orders	1. Nurse to start, pause, or discontinue peripheral or central venous access device PRN 2. Flush IV line with 10-20ml saline before and after each medication dose or as needed 3. Flush PORT or Central Line with 500u/5ml Heparin as FINAL flush or as needed 4. Dispense DME pump with all necessary supplies for home infusion
Anaphylaxis kit per pharmacy protocol (IM .3mg Epinephrine, IV 50mg Diphenhydramine, and IV 500mL 0.9% NS)	
Refills:	<input type="checkbox"/> X 1 year <input type="checkbox"/> _____ doses

PRESCRIBER INFORMATION

Prescriber Name:	NPI:	
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