

ORENCIA® Infusion Form
Adults – RA

Fax Referral To:
877-438-9380



Birmingham, AL
F: 205-271-9971

Huntsville, AL
F: 256-417-6408

Knoxville, TN
F: 865-934-0249

Nashville, TN
F: 615-645-4791

Chantilly, VA
F: 703-935-2061

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: M F Height: _____ Weight: _____
Phone Number: _____ Email Address: _____
Allergies: _____ Is the patient Diabetic: Y N ICD-10 Code: _____
Emergency Contact: _____ Phone Number: _____

Primary Diagnosis: _____ Rheumatoid Arthritis with Rheumatoid factor
_____ Rheumatoid Arthritis without Rheumatoid factor
_____ Other: _____

Please attach the following: 1. List of current Medications, Previous Drug Therapy History, including therapies trailed/failed and date of last administration: Agent: _____ Date: _____ Desired Washout Period: _____ weeks 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs including TB Screening Results and Hepatitis B Screening (including Hep B surface antigen & Hep B Core Antibody)

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: ORENCIA® (abatacept)

Administer Orencia IV over 30 minutes. ***Select Dose Below*** _____ # Refills (Recommend 5)

Select	Body Weight	Dose	Number of Vials
☐	Less than 60 kg	500 mg	2
☐	60 to 100 kg	750 mg	3
☐	More than 100 kg	1000 mg	4

New Start: Following initial administration, administer on 0, 2 and 4 weeks and then every 4 weeks.

Maintenance Dose: Administer every 4 weeks

Other Orders: _____

Pre-Medication Orders: Acetaminophen 650 mg PO administered 30 minutes prior to infusion

*adjust to patient's needs

Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Prescriber's Signature (SIGN BELOW)

By signing this form and utilizing our services, I am also authorizing ContinuumRX to serve as my prior authorization agent with medical and pharmacy insurance providers.

Physician's NPI#

Physician's Address

Prescriber's Signature

Date