INTRAMED Plus
infusion services

ORENCIA®
Pediatrics

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____

Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):

Primary Diagnosis: _____ Juvenile Rheumatoid Arthritis with Systemic Onset ICD-10 Code: M08.2 _____
_____ Juvenile Rheumatoid Polyarthritis (seronegative) ICD-10 Code: M08.3 _____
_____ Pauciarticular Juvenile Rheumatoid Arthritis ICD-10 Code: M08.4 _____
_____ Unspecified Juvenile Rheumatoid Arthritis ICD-10 Code: M08. _____
_____ Other ICD-10 Code: _____ Diagnosis: _____

Allergies: _____ (or attach list)

Patient
Weight: _____ lbs.
Height: _____ in.

3. Clinical Information – Please fax with Infusion Order Form:

- Clinical MD Notes, labs, test supporting primary diagnosis
  - TB Screening Results
  - Hepatitis B Screening (including Hep B surface antigen & Hep B Core Antibody)
- Previous Drug Therapy History, including therapies trailed/failed and date of last administration:

Agent: _____ Date: _____ Desired Washout Period: _____ weeks

ORENCIA® (abatacept) J Code: J0129

4. Drug Order: (Pediatrics > 6 y.o.)

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

Select	Body Weight	Dose	Number of Vials
❑	Less than 75 kg	**10/kg**	weight based dosing
❑	75 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.
❑ On-going Maintenance: Administer every 4 weeks
❑ Other Orders: _____

Pre-Medication Ordres: Acetaminophen 650 mg PO administered 30 minutes prior to infusion
*adjust to patient's needs

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

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

5. Physician Signature: _____ / _____ Date: _____
Dispense as written Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION	**INFUSION CENTER LOCATIONS**
CENTRAL FAX 803.999.1754	**BERKELEY CHARLESTON COLUMBIA GREENVILLE**
	CENTRAL INTAKE PHONE 803.999.1760