

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)

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

Patient
Weight: _____ lbs.
Height: _____ in.

ORENCIA® (abatacept)

J Code: J0129

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

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

Select	Body Weight	Dose	Number of Vials
<input type="checkbox"/>	Less than 75 kg	10/kg	weight based dosing
<input type="checkbox"/>	75 to 100 kg	750 mg	3
<input type="checkbox"/>	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
CENTRAL FAX 803.999.1754

CENTRAL INTAKE PHONE
803.999.1750