Abatacept (Orencia)

Provider Order Form rev. 12/01/2021

AleraCare
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PATIENT INFORMATION

Patient Name: DOB:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

ICD-10 CODE

- ☐ E88.01 Alpha 1 proteinase inhibitor deficiency
- ☐ M06.9 Adult Rheumatoid Arthritis
- ☐ M08.9 Polyarticular Juvenile Idiopathic Arthritis
- ☐ L40.50 Adult Psoriatic Arthritis
- ☐ Other: _____

MEDICATION ORDER

☐ **Abatacept** (Orencia) in 100ml 0.9% sodium chloride, intravenous infusion over 30 minutes (use in line filter 0.2 to 1.2 micron)

- Dose: ☐ 500mg / ☐ 750mg / ☐ 1000mg / ☐ _____mg
- Frequency: ☐ induction: week 0, 2, and 4, then every 4 weeks / ☐ maintenance: every 4 weeks / ☐ other: _____
- Route: ☑ intravenous
- Infuse over 30 minutes
- Remove equal volume from bag prior to adding medication

☑ Flush with 0.9% sodium chloride at infusion completion

☐ **abatacept** (Orencia) injection

- Dose: ☐ 50mg/ ☐ 87.5mg/ ☐ 125mg
- Frequency: ☐ weekly / ☐ other: _____
- Route: ☑ subcutaneous

SPECIAL INSTRUCTIONS

☐ Patient is required to stay for 30-minute observation period
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

Provider Name (Print) **Provider Signature** **Date**

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)

☐ ANA (SLE) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months