

PRESCRIPTION ORDER FORM

ORENCIA (abatacept)



Central Intake Fax: 800-504-0870

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- Negative TB Results
- Hep B Panel

PRIMARY DIAGNOSIS

- | | |
|--|--|
| ☐ M05.79 Rheumatoid arthritis with rheumatoid factor, multiple sites without organ or systems involvement | ☐ M06.89 Other specified rheumatoid arthritis, multiple sites |
| ☐ M05.9 Rheumatoid arthritis with rheumatoid factor, unspecified | ☐ M06.9 Rheumatoid arthritis, unspecified |
| ☐ M06.00 Rheumatoid arthritis without rheumatoid factor, unspecified site | ☐ Other: _____ |

PRE-MEDICATIONS - **No Standard premedications typically indicated**

- | | | | |
|---|--|---|--|
| ☐ Diphenhydramine 25mg PO | ☐ Pepcid 20mg PO | ☐ Cetirizine 10mg PO | ☐ Solu-Cortef 40mg IVP |
| ☐ Diphenhydramine 50mg PO | ☐ Pepcid 20mg IVP | ☐ Tylenol 650mg PO | ☐ Solu-Cortef 125mg IVP |
| ☐ Diphenhydramine 25mg IVP | | | ☐ Other: _____ |
| ☐ Diphenhydramine 50mg IVP | | | |

PRIMARY MEDICATION ORDER - **If necessary, Suite Life will round dose up/down according to payor guidelines**

- ☐ Weight <60kg: Orenzia 500mg IV at week 0, 2, 4, and every 4 weeks thereafter infuse over 30-60 mins
- ☐ Weight 60kg-100kg: Orenzia 750mg IV at week 0, 2, 4, and every 4 weeks thereafter infuse over 30-60 mins
- ☐ Weight >100kg: Orenzia 1000mg IV at week 0, 2, 4, and every 4 weeks thereafter infuse over 30-60 mins
- ☐ Orenzia _____mg IV every _____ weeks
- ☐ Orenzia _____mg Subcutaneous every _____ weeks
- ☐ Other: _____
- First Dose: ☐ Y ☐ N ☒ Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

- ☒ Start PIV/ACCESS CVC ☒ Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
- ☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- ☒ Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
- ☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI AND License:	☐ Email:

Provider Signature

Date