

Richmond
7110 Forest Ave, Suite 203
Richmond, VA 23226



Prince George
2025B Waterside Rd
Prince George, VA 23875

Physician Order - Orencia (abatacept)

PATIENT INFORMATION	
Name:	DOB:
Allergies:	Phone Number:

REFERRAL STATUS
<input type="checkbox"/> New Referral <input type="checkbox"/> Dose/Frequency Change <input type="checkbox"/> Order Renewal

Location Preference (optional)
<input type="checkbox"/> Richmond <input type="checkbox"/> Prince George

* * If the patient has a central line - we need official placement report, diagnostic imaging to confirm tip placement and date of last access * *

DIAGNOSIS AND ICD 1-0 CODE	
<input type="checkbox"/> Rheumatoid Arthritis	M06.9
<input type="checkbox"/> Arthropathic Psoriasis	L40.50
<input type="checkbox"/> Juvenile Rheumatoid Arthritis	M08.00
<input type="checkbox"/> Other: _____	ICD10 _____

REQUIRED DOCUMENTATION	
<input type="checkbox"/> This signed order form by the provider	<input type="checkbox"/> Clinical/Progress Notes
<input type="checkbox"/> Patient Demographics AND Insurance Information	<input type="checkbox"/> Labs and Tests Supporting Primary Dx
<input type="checkbox"/> Hepatitis B Test Results: HBsAg	
<input type="checkbox"/> QuantiFERON Gold TB Test Results	
<input type="checkbox"/> Patient currently receiving same therapy at _____	Last dose: _____
List Tried & Failed Therapies, including duration of treatment	
1)	
2)	
3)	

MEDICATION ORDERS**	
Dose	<input type="checkbox"/> <60kg - 500mg <input type="checkbox"/> Initial: Infuse IV over 30 minutes at week 0, 2, 4, then every 4 weeks <input type="checkbox"/> 60-100kg - 750mg <input type="checkbox"/> Maintenance: Infuse IV over 30 minutes every 4 weeks <input type="checkbox"/> >100kg - 1000mg
Patient Weight = _____ kg	Patient Height = ____ ft ____ in
Duration: <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> doses _____	

**Patient weight is required for all weight based therapies - please indicate weight in kilograms.

PREMEDICATIONS
<input type="checkbox"/> Acetaminophen 650mg PO prior to Orencia infusion <input type="checkbox"/> Diphenhydramine 25mg PO prior to Orencia infusion <input type="checkbox"/> Methylprednisolone 40mg slow IVP <input type="checkbox"/> Other: _____

Please note: if an infusion reaction occurs, the on-call physician will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing.

PRESCRIBER INFORMATION			
Prescriber Name:	NPI:	Contact:	
Phone:	Fax:	Email:	
Prescriber Signature:	Date:		

Contact us with questions at: 804-442-3558 or email referrals@theinfusionsolution.com
 Fax completed form and ALL documentation to 804-554-5848
 All information contained in this form is strictly confidential and will become part of the patient's record.