



INFUSION ORDERS-ORENCIA (ABATACEPT)

PATIENT INFORMATION
Name: DOB:
Allergies: Date of Referral:

REFERRAL STATUS
New Referral Dose or Frequency Change Order Renewal

INFUSION OFFICE PREFERENCES (Optional)
Preferred Location\*:

\*List of infusion center locations may be found at: https://metroinfusioncenter.com/infusion-center-locations/
Please note: Requests will be accommodated based on infusion center availability and are not guaranteed.

DIAGNOSIS AND ICD 10 CODE
Rheumatoid Arthritis (RA) ICD 10 Code: M05.9
Systemic Juvenile Idiopathic Arthritis (SJIA) ICD 10 Code: M08.20
Other: ICD 10 Code:

REQUIRED DOCUMENTATION
This signed order form by the provider Clinical/Progress notes
Patient demographics AND insurance information Labs and Tests supporting primary diagnosis
TB Test Results
List Tried & Failed Therapies, including duration of treatment:

MEDICATION ORDERS
Dosing (RA and SJIA >75kg) Orencia 500mg (Weight < 60kg) IV at Week 0, 2, 4 then every 4 weeks
Orencia 750mg (Weight 60-100kg) IV at Week 0, 2, 4 then every 4 weeks
Orencia 1000mg (Weight >100kg) IV at Week 0, 2, 4 then every 4 weeks
Maintenance: Orencia mg IV every 4 weeks
SJIA Dosing (<75kg) Orencia 10mg/kg IV at Week 0, 2, 4 then every 4 weeks (Max dose= 1000mg)
Maintenance: Orencia 10mg/kg IV every 4 weeks (Max dose = 1000mg)
Patient Weight = kg
Refills: X 6 months X 1 year doses

PRESCRIBER INFORMATION
Prescriber Name:
Office Phone: Office Fax: Office Email:
Prescriber Signature: Date:

All information contained in this order form is strictly confidential and will become part of the patient's medical record.
Contact us with questions at: (877) 448-3627
Fax Completed Form and all documentation to: 866-507-1164