immersiv HEALTH

ORENCIA® ORDER FORM

FAX TO: 855.694.4656

PATIENT INFORMATION

PATIENT NAME: _____ **PHONE:** _____

DATE OF BIRTH: _____ **SEX:** ☐ M ☐ F **HEIGHT:** _____ **WEIGHT:** _____ ☐ LBS ☐ KG

ALLERGIES: _____ **PREFERRED CLINIC:** _____

REFERRAL STATUS: ☐ NEW REFERRAL ☐ ORDER CHANGE ☐ ORDER RENEWAL

DIAGNOSIS & CLINICAL DOCUMENTATION

☐ M05. ___ Rheumatoid Arthritis with rheumatoid factor

☐ M06. ___ Rheumatoid Arthritis without rheumatoid factor

☐ ICD-10 CODE: _____ DESCRIPTION: _____

REQUIRED DOCUMENTATION

☐ Insurance Information ☐ List of Medications ☐ Tried & Failed Therapies ☐ Most Recent History & Physical ☐ Negative TB & HEP-B screenings

MEDICATION ORDER

***For Patients Weighing Less Than 60kg.**

☐ **LOADING:** Orenica® (abatacept) 500mg IV in 100ml NS over 30 minutes at Week 0, Week 2 and Week 4

☐ **MAINTENANCE:** Orencia® (abatacept) 500mg IV in 100ml NS over 30 minutes every 4 weeks

***For Patients Weighing 60kg TO 100KG**

☐ **LOADING:** Orenica® (abatacept) 750mg IV in 100ml NS over 30 minutes at Week 0, Week 2 and Week 4

☐ **MAINTENANCE:** Orencia® (abatacept) 750mg IV in 100ml NS over 30 minutes every 4 weeks

***For Patients Weighing GREATER Than 100kg**

☐ **LOADING:** Orenica® (abatacept) 1000mg IV in 100ml NS over 30 minutes at Week 0, Week 2 and Week 4

☐ **MAINTENANCE:** Orencia® (abatacept) 1000mg IV in 100ml NS over 30 minutes every 4 weeks

☐ **OTHER:** _____

☑ REFILL X 12 MONTHS UNLESS OTHERWISE NOTED HERE: _____

Patient to be observed for 30 minutes following the first administration.
In the event of an adverse reaction occurring in the infusion clinic, utilize the Immersiv Health adverse reaction protocol.

PRE-MEDICATIONS

PO

☐ Acetaminophen: 650 mg
☐ Cetirizine: 10 mg
☐ Diphenhydramine: 25 mg

IV

☐ Methylprednisolone: 125 mg
☐ Diphenhydramine: 25 mg

☐ **OTHER:** _____ ☐ PO ☐ IV

PRESCRIBER INFORMATION

PROVIDER NAME: _____ **NPI #:** _____

EMAIL: _____ **PHONE:** _____ **FAX:** _____

ADDRESS (INCLUDE CITY, STATE, ZIP): _____

SUPERVISING PHYSICIAN: _____ **CONTACT NAME:** _____
(IF APPLICABLE)

SIGNATURE: _____ _____ **DATE:** _____
(NO STAMPS)

SUBSTITUTION PERMITTED DISPENSE AS WRITTEN