Infusion ASSOCIATES

Phone:616-954-0600 Fax: 616-954-1675

# Orencia IV Infusion

*Please fax a copy of patient's Demographics, Insurance Information, Current Lab Results, H&P, and Current Medications and **Recent Visit Notes***

**Referral status:** □ NEW referral □ Dose or frequency change □ Order renewal

**Date**: _____/_____/_____

**Patient Name**: _____ **DOB**: _____/_____/_____

**Allergies**: _____ **Patient Weight:** _____lbs / kg **Height:**_____

***ICD-10*** : _____, _____, _____

In the past year, what medications for the above diagnosis has the patient tried and failed?
□ N/A continuation of treatment

| Drug | Dose | Dates of use |
|---|---|---|
| | | |
| | | |

Will the patient be receiving other biologic therapy in combination with Orencia?
□ No □ Yes, rationale for use:_____

**TB verification** ***(circle one):*** **TB skin test** **TB spot/Quantiferon blood test** **Chest X-RAY**

Result Date: _____/_____/_____ Result ***(circle one):*** **Positive** **Negative**

**Labs to be collected**: □CMP □CBC w/o diff □CBC w/diff □CBC w/man diff □CRP □ESR □ Other:_____

**Lab Frequency:** □ EVERY infusion □ Every OTHER infusion □ Other:_____

# Orencia (abatacept) IV

□ **500mg** (<60kg) □ **750mg** (60-100kg) □ **1000mg** (>100kg) □ **Other: _____**

**Frequency: □ Initial Dose- 0, 2, 4 wks THEN every 4 weeks**
**□ q 4 weeks**
**□ Other: _____**

□ **Continuation of treatment** **Rx Expiration Date: _____/_____/_____**

**Printed provider name**: _____

**Provider signature**: _____

**Office phone number:** _____ **Fax number:** _____