



ORENCIA® (ABATACEPT) ORDER FORM

(* - Required Fields)

STAT REQUEST
(*REASON MUST BE PROVIDED BELOW)

New Referral Order Renewal Medication/Order Change
 Benefits Verification Only Discontinuation Order

PATIENT INFORMATION

NAME*:	DOB*:	SEX:	M	F
ADDRESS:	PHONE:			
WEIGHT: LBS KG	HEIGHT:	EMAIL:		
ALLERGIES:				

PHYSICIAN INFORMATION

PHYSICIAN NAME*:		PRACTICE NAME:	
ADDRESS:		OFFICE CONTACT*:	
PHONE:	FAX:	EMAIL (FOR UPDATES):	

ORENCIA ORDER*: **ICD-10*:** _____
(SELECT ONE OF THE FOLLOWING)

Initial/Reload Dosing and then Maintenance Dosing:
 500 750 1000 mg IV on weeks 0, 2, and 4, then every 4 weeks thereafter

OR

Maintenance Dosing Only: 500 750 1000 mg IV every 4 weeks

Physician Signature* _____ Date*(Order is Valid for One Year) _____
Infusion will be administered per MPP policy and protocols

REQUIRED DIAGNOSIS:

Psoriatic Arthritis

Rheumatoid Arthritis

Other _____

***STAT REASON:**
(STAT request will be assessed per MPP policy and protocol)

REQUIRED DOCUMENTATION CHECKLIST:

Patient Demographics

Insurance Card/Information

Clinical/Progress Notes supporting DX

Current Medication List and H&P

HepB Core (if available)

HepB Surf Ag (w/in 36 months)

TB Results (w/in 6 months)-if positive, need negative chest Xray and negative TSpot

Last Infusion/Injection Date: _____

STANDING LAB ORDERS: CMP CBC

Labs to be drawn by Infusion Center Frequency _____

NOTES/ADDITIONAL COMMENTS:

Locations:

-----**Colorado**-----

Lakewood

-----**Florida**-----

Jacksonville
 Kissimmee
 Port St. Lucie
 Suncoast
 Winter Park

-----**Texas**-----

Arlington
 Cedar Hill
 Dallas
 Denton
 Ft. Worth
 Irving
 Rockwall
 Southlake
 Flower Mound
 Plano
 Tyler