



MEDICATION ORDERS

ORENCIA (ABATACEPT)

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

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

INFUSION OFFICE PREFERENCE (Optional)
Preferred Location: <input type="checkbox"/> Montgomery <input type="checkbox"/> Prattville

DIAGNOSIS AND ICD 10 CODE
<input type="checkbox"/> Rheumatoid Arthritis (RA) ICD 10 Code: M06.9
<input type="checkbox"/> Systemic Juvenile Idiopathic Arthritis (SJIA) ICD 10 Code: M08.20
<input type="checkbox"/> Other: _____ ICD10 Code: _____

REQUIRED DOCUMENTATION/TESTING	
<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 diagnosis
	<input type="checkbox"/> TB Test Results

List Tried & Failed Therapies, including duration of treatment:

- 1)
- 2)
- 3)

MEDICATION ORDERS	
Dosing (RA and SJIA >75kg)	<input type="checkbox"/> Orencia 500mg (weight <60kg) IV at Week 0, 2, 4, then every 4 weeks <input type="checkbox"/> Orencia 750mg (weight <60-100kg) IV at Week 0, 2, 4, then every 4 weeks <input type="checkbox"/> Orencia 1000mg (weight >100kg) IV at Week 0, 2, 4, then every 4 weeks <input type="checkbox"/> Maintenance: Orencia _____ mg IV every 4 weeks
SJIA Dosing (<75kg)	<input type="checkbox"/> Orencia 10mg/kg IV at Week 0, 2, 4, then every 4 weeks (MAX dose = 1000mg) <input type="checkbox"/> Maintenance: Orencia 10mg/kg IV every 4 weeks (MAX dose = 1000 mg)
Refills: <input type="checkbox"/> x 6 months <input type="checkbox"/> x 1 year <input type="checkbox"/> _____ doses	
<ul style="list-style-type: none">• New orders and progress notes required at least once yearly. A medication substitution may be required based on insurance payer policy due to preferred versus non-preferred medications or based on payer step therapy guidelines.• Please note: if an infusion reaction occurs, the Montgomery Cancer Center provider will order appropriate rescue medications as deemed medically necessary. This may also include pausing, reducing the rate of infusion or discontinuing the medication.	

PROVIDER INFORMATION	
Office Contact Name:	
Prescribing Providers Name:	Provider NPI:
Office Address:	City: State: Zip:
Office Phone Number:	Office Fax Number:
Physician Signature:	Date:

Contact us with questions at: Montgomery (334) 273-7000 or Prattville (334) 351-1000

Fax completed form and all documentation to Montgomery (334) 260-2011 or Prattville (334) 358-1207