



MRN: _____
 DOB: _____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

STANDARD Orenzia® (abatacept) PLAN OF TREATMENT for Pediatric – (6 years of age or older)

NOTE: Patient *may be ineligible* to receive abatacept if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new or worsening diagnosis of COPD or respiratory status, and/or surgery.

1. Patient Name: _____ Height (inches): _____ Weight (lbs): _____

2. Allergies: _____

3. Diagnosis: * Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing

- M08.0** _____ Unspecified Juvenile Rheumatoid Arthritis **M08.2** _____ Juvenile Rheumatoid Arthritis with Systemic Onset
 M08.3 Juvenile Rheumatoid Polyarthritis (seronegative) **M08.4** _____ Pauciarticular Juvenile Rheumatoid Arthritis
 Other **ICD-10 Code:** _____ **Diagnosis description:** _____

4. Pre-medications: Administered 30 minutes prior to infusion as selected:

**Product information does not suggest premedication and will only be given as specified by referring MD.*

- a) Acetaminophen _____ mgs PO or Liquid 160mg/5ml dose of _____ mls as specified by referring MD
 b) Diphenhydramine: _____ mgs PO or _____ mgs IV Liquid 12.5mg/5ml dose of _____ mls as specified by referring MD
 c) Pre-medicate with other: _____

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If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES.

5. Dose: Orenzia® (abatacept) dosage per 100 ml Sodium Chloride 0.9% IV to infuse over at least 30 minutes.

Orenzia® (abatacept) dosage will be based on the following guidelines provided by Bristol-Myers Squibb

Body Weight of Patient	Dose	Number of 250mg (abatacept) Vials
Less than 75 kg	10mg/kg	Weight based dose
75 to 100 kg	750 mg	3
More than 100 kg	1000 mg	4

6. Frequency: _____ Induction orders to be completed at 0 week, 2 week, and 4 weeks, and then every 4 weeks thereafter
 _____ Orders every 4 weeks (maintenance).
 _____ Special Orders: _____

Lab orders with infusions: _____

7. Physician's Signature: _____ / _____ Date: _____
 No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____

8. Fax updated supporting clinical MD notes with each order renewal or change in orders
Infusion order forms available at www.palmettoinfusion.com



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Guidelines for Prescribing Orenzia® (abatacept) for Rheumatology for Pediatric – (6 years of age or older)
(Required documentation with all initial referrals)

Patient Name: _____

Referral Date: _____

Include signed and completed Plan of Treatment. (MD must complete sections 1-8)
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

Include patient demographic information and insurance information. (Copy of insurance cards if available)

Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or
contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.
• Orenzia® is indicated for moderately to severely active polyarticular juvenile idiopathic arthritis in pediatric patients 6 years of
age and older. ORENCIA may be used as monotherapy or concomitantly with methotrexate.

If patient is switching biological therapies, then MD must specify wash-out period prior to starting Orenzia®
as specified of _____ weeks. Last known biological therapy: _____ and last date
received: _____. (Include copy of last Orenzia® infusion record if available and currently on therapy)

Other as requested: _____

Pre-Screening: (TB and Hepatitis screening results must be available prior to start of therapy and within last 12 months)

Required TB screening results: PPD or QuantiFERON Gold Test.
(* If screening results are positive or indeterminate, then a negative CXR result is required.)

Required Hepatitis screening to include: Hepatitis B Surface Antigen results.

** Warnings/Precautions: Patient should not have an active ongoing infection, signs or symptoms of malignancy, or invasive fungal
infection. COPD patients may develop more frequent respiratory adverse events. Orenzia® in patients with RA and COPD should be
undertaken with caution and such patients should be monitored for worsening of their respiratory status. Blood Glucose Monitoring:
Orenzia® contains maltose and can interfere with the readings of blood glucose monitors that use test strips with (GDH-PQQ), resulting
in falsely elevated blood glucose readings on the day of infusion. Hepatitis B Reactivation: Monitor HBV carriers during and several
months after therapy. If reactivation occurs, stop Orenzia® and begin anti-viral therapy. Evaluation of immunizations should be
completed prior to and live vaccines should not be given before or concurrently with Orenzia®. See full prescribing information.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's
insurance company for eligibility. Our office will notify you if any further information is required. We will review financial
responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.