Referral Status:			MRN:
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Orencia® (abatacept) Plan of Treatment for Rheumatology

PATIENT DEMOGRAPHICS:

Date of Referral:	Patient's Phone:
Patient Name:	Address:
Date of Birth:	City, State, Zip:
Height in inches: / Weight: LB or KG	Gender: / Allergies: ☐ See list ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

- ☐ M05._______ - Rheumatoid Arthritis with Rheumatoid factor
- ☐ M06._______ - Rheumatoid Arthritis without Rheumatoid factor
- ☐ ________ - Other:

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	TB screening results
6	HBV screening/labs as required by payor

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
	NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

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.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV

Medication			
Diphenhydramine	☐ 25mg	☐ 50mg	
Methylprednisolone	☐ 40mg	☐ 125mg	☐ Other:
Famotidine	☐ 20mg	☐ 40 mg	
Other:	☐		

PO

Medication				
Acetaminophen	☐ 325mg	☐ 500mg	☐ 650mg	☐ 1000mg
Famotidine	☐ 20mg	☐ 40mg		
Diphenhydramine	☐ 25mg	☐ 50mg		
Fexofenadine	☐ 60mg	☐ 180mg		
Cetirizine	☐ 10mg			
Loratadine	☐ 10mg			
Other:	☐			

MEDICATION:

☑ Orencia® (abatacept) dosage per 100 ml NS to infuse over at least 30 minutes.

DOSE:

☐ Dosage based on the following guidelines from the FDA package labeling.

Patient Weight	Dose	250 mg vials
<60 kg	500 mg	2
60 to 100kg	750 mg	3
>100 kg	1000 mg	4

☐ Flat Dose: ______mg

FREQUENCY:

- ☐ Induction: To be given at 0 week, 2 week, and 4 weeks
- ☐ Maintenance: Every 4 weeks
- ☐ Other:____

SPECIAL/LAB ORDERS:

☐ ____
____

Prescriber confirms that the patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment. Prescriber to monitor patient for symptoms of HBV infection and reactivation as clinically appropriate.

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

- ☑ Start PIV/Access CVC
- ☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures) DATE:

Dispense as written/Brand medically necessary	Substitution permitted	

Checklist for referrals to AccuRX Infusion:

Fax referral to 1.866.990.3192

- ☐ **Patient demographics – address, phone number, SS#, etc.**
- ☐ **Insurance Information – copy of the card(s) if possible**
- ☐ **Plan of Treatment/Orders**
- ☐ **Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs.**
- ☐ **Any lab results or other diagnostic procedures to support the diagnosis**

Palmetto Infusion 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. AccuRX Infusion Call Center 888.410.0317. Thank you for the referral.

www.AccuRXInfusion.com

02/08/2023

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