

Referral Status:		MRN:	
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change	<input type="checkbox"/> Order Renewal	
Patient preferred clinic:			

# Orencia® (abatacept) Pediatric Standard Plan of Treatment

## 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 2<sup>ND</sup> AND 3<sup>RD</sup> DIGITS TO COMPLETE ICD 10 FOR BILLING)

M08.0 - Unspecified Juvenile Rheumatoid Arthritis	M08.2 - Juvenile Rheumatoid Arthritis with Systemic Onset
M08.4 - Polyarticular Juvenile Rheumatoid Arthritis	M08.3 - Juvenile Rheumatoid Polyarthritis (seronegative)
- Other:	

## REQUESTED DOCUMENTATION: PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

1 Insurance information	IF NO:	IF YES:
2 Most recent History & Physical	PLEASE STATE	LAST INFUSION DATE:
3 Full medication list	REQUIRED WASHOUT	NEXT INFUSION DATE:
4 Tried and failed therapies	FROM PREVIOUS	<b>IF ORDER CHANGE:</b>
5 TB screening results	THERAPY:	
6 HBV screening/labs as required by payor		
		<b>Continue current order until insurance approved</b>

## 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	Diphenhydramine	25mg	50mg		PO	Acetaminophen	325mg	500mg	160mg/5ml	mls
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg	12.5mg/5ml:	mls
	Other:					Loratadine	10mg			
					Other:					

## DRUG PRODUCT: FREQUENCY:

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

Induction: To be given at 0 week, 2 week, and 4 weeks, and then every 4 weeks thereafter

Maintenance: Every 4 weeks

Other: \_\_\_\_\_

## DOSE: SPECIAL/LAB ORDERS:

Dose based on guidelines below from the FDA package labeling

\_\_\_\_\_


Patient Weight	Dose	250mg Vials
< 75kg	10mg/kg	undefined
75kg to 100kg	750mg	3
More than 100kg	1000mg	4

Flat dose: \_\_\_\_\_ mg

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: ADVERSE REACTION & ANAPHYLAXIS ORDERS:

<input checked="" type="checkbox"/> Start PIV/Access CVC	Administer acute infusion and anaphylaxis medications per Palmetto Infusion/AccuRX standing adverse reaction orders, which can be found at our website or scan here.	
<input checked="" type="checkbox"/> Flush device per facility standard flushing procedure		

## 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](http://www.AccuRXInfusion.com)