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

Orencia® (abatacept) 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 2ND AND 3RD 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 REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		**IF ORDER CHANGE:**
5	**REQUIRED:** TB screening for new start patients		☐ **Continue current order until insurance approved**
6	**REQUIRED**: **HBsAg, anti-HBc, and anti-HBs**		

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:

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

DOSE:

☐ 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

FREQUENCY:

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

☐ 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 and TB 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

☑ Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion 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	

Palmetto INFUSION

Checklist for referrals to Palmetto Infusion: Fax referral to 1.866.872.8920

- [ ] **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 patient and refer them to any available co-pay assistance as required. Palmetto Infusion Call Center 800.809.1265. Thank you for your referral.

www.PalmettoInfusion.com