medix infusion

Orencia Order Form
(abatacept)

FAX TO: 972.499.9210

PATIENT INFORMATION

Patient Name: _____ DOB: _____ Phone: _____ Sex: M / F Ht: _____ Wt: _____ lbs / kg

Primary Language: _____ Allergies: _____

Patient Preferred Location: _____

<ICD 10 CODE REQUIRED> DIAGNOSIS & CLINICAL INFORMATION

ICD 10 Code (PROVIDE COMPLETE CODE)

☐M05._____ Rheumatoid Arthritis, w/ Rheumatoid Factor
☐ M06._____ Rheumatoid Arthritis, w/o Rheumatoid Factor
Other: _____

REQUIRED: **Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.**
LAB RESULTS: **Include Negative Hepatitis B within 3 years & Negative TB within 12 months.**

PRESCRIPTION

Pre-Medications

☐ Acetaminophen: 650 mg PO
☐ Cetirizine: 10 mg PO
☐ Diphenhydramine: 25 mg PO
☐ Diphenhydramine: 25 mg IVP
☐ Famotidine: 20 mg PO
☐ Methylprednisolone: 125 mg SIVP
☐ Other: _____

Lab Orders+

Required: Negative TB, annually
+Medix Infusion will draw maintenance labs unless otherwise directed by Referring Provider.

Orencia (abatacept)

Infuse in 100 mL of 0.9% Sodium Chloride over at least 30 minutes via pump with 0.2-micron filter.

☐ Loading Dose:
IV: (wt < 60 kg): Infuse 500 mg (2 vials) at weeks 0, 2, 4
IV: (wt 60 kg – 100 kg): Infuse 750 mg (3 vials) at weeks 0, 2, 4
IV: (wt > 100 kg): Infuse 1000 mg (4 vials) at weeks 0, 2, 4

☐ Maintenance: **for one year**
IV: (wt < 60 kg): Infuse 500 mg (2 vials) every 4 weeks for one year
IV: (wt 60 kg – 100 kg): Infuse 750 mg (3 vials) every 4 weeks for one year
IV: (wt > 100 kg): Infuse 1000 mg (4 vials) every 4 weeks for one year

Patient Weight: _____ lbs **or** _____ kg

In the event of an adverse reaction occurring at a Medix Infusion suite, utilize the Medix Infusion adverse reaction protocol.

Post Treatment Observations: The patient is observed for 30 minutes following the first infusion.

Comments: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ ***Signature:*** _____

Date: _____ NPI #: _____ Specialty: _____

Supervising Physician: _____ (If Applicable)

Address: _____ City: _____ State: _____ Zip:_____

Contact Name: _____ Phone: _____ Fax: _____ Email: _____