

INFUSION & MEDICAL CENTER

1. Patient Name _____ **DOB** _____ **Patient Phone/Cell #** _____
Patient demographic and insurance information to be faxed with Infusion Order Form

2. Medical Information (Please select primary diagnosis and complete ICD10 Code):
 Primary Diagnosis: _____ Juvenile Rheumatoid Arthritis with Systemic Onset ICD-10 Code: M08.2 _____
 _____ Juvenile Rheumatoid Polyarthritis (seronegative) ICD-10 Code: M08.3 _____
 _____ Pauciarticular Juvenile Rheumatoid Arthritis ICD-10 Code: M08.4 _____
 _____ Unspecified Juvenile Rheumatoid Arthritis ICD-10 Code: M08. _____
 _____ Other ICD-10 Code: _____ Diagnosis: _____

Allergies: _____ (or attach list)

Patient
Weight: _____ lbs.
Height: _____ in.

3. Clinical Information – Please fax with Infusion Order Form:
 • Clinical MD Notes, labs, test supporting primary diagnosis
 ○ TB Screening Results
 ○ Hepatitis B Screening (including Hep B surface antigen & Hep B Core Antibody)
 • Previous Drug Therapy History, including therapies trailed/failed and date of last administration:
 Agent: _____ Date: _____ Desired Washout Period: _____ weeks

ORENCIA® (abatacept) J Code: J0129

4. Drug Order: (Pediatrics > 6 y.o.)
 Administer Orencia IV over 30 minutes. ***Select Dose Below*** _____ # Refills (Recommend 5)

Select	Body Weight	Dose	Number of Vials
<input type="checkbox"/>	Less than 75 kg	10/kg	weight based dosing
<input type="checkbox"/>	75 to 100 kg	750 mg	3
<input type="checkbox"/>	More than 100 kg	1000 mg	4

- New Start: Following initial administration, administer on 0, 2 and 4 weeks and then every 4 weeks.
- On-going Maintenance: Administer every 4 weeks
- Other Orders: _____

Pre-Medication Ordres: Acetaminophen 650 mg PO administered 30 minutes prior to infusion
 *adjust to patient's needs

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing this form and utilizing these services, I am authorizing Intramed Plus to serve as my prior authorization agent with medical and pharmacy insurance providers.

5. Physician Signature: _____ / _____ Date: _____
 Dispense as written Substitution permitted

Printed Physician's Name: _____ Contact Phone #: _____

FAX ALL INFORMATION CENTRAL FAX 803.999.1754	INFUSION CENTER LOCATIONS COLUMBIA CHARLESTON GREENVILLE CENTRAL INTAKE PHONE 803.999.1760
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