INTRAMED Plus
infusion services

ORENCIA®
Adults – RA

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: _____ Rheumatoid Arthritis with Rheumatoid factor — ICD-10 Code: M05. _____

_____ Rheumatoid Arthritis without Rheumatoid factor — ICD-10 Code: M06. _____

_____ Other: _____ — ICD-10 Code: _____

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:

Administer Orencia IV over 30 minutes. ***Select Dose Below*** _____ # Refills (Recommend 5)

Select	Body Weight	Dose	Number of Vials
❑	Less than 60 kg	**500 mg**	2
❑	60 to 100 kg	**750 mg**	3
❑	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 Orders: 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
ALTERNATE FAX 803.999.1887

INFUSION CENTER LOCATIONS
COLUMBIA CHARLESTON GREENVILLE
CENTRAL INTAKE PHONE 803.999.1960

JUN 2020