INTRAMED Plus
infusion services

# ORENCIA®
## Pediatrics

## 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

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### 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 |
|---|---|---|---|
| ❑ | Less than 75 kg | **10/kg** | weight based dosing |
| ❑ | 75 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 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**
**ALTERNATE FAX 803.999.1887**

**INFUSION CENTER LOCATIONS**
**COLUMBIA CHARLESTON GREENVILLE**
**CENTRAL INTAKE PHONE 803.999.1960**