



Orencia (abacept)

New Referral Continuing Treatment Medication Order Change

Patient Information:

Name: _____
Date: _____
DOB: _____
SS#: _____
Phone #: _____
Email: _____

Physician Information:

Referring Physician: _____
Address: _____

Phone #: _____
Fax #: _____

Medication Orders

Patient Weight: _____ kg Patient Height: _____ inches

First Dose Maintenance Dose

Dosing: **LOADING DOSES: 10 MG/KG IV @ 0 weeks, 2 weeks, 4 weeks, and then every 4 weeks**

10 MG/KG IV every 4 weeks

Premeds(if applicable): _____

Indication / Diagnosis:

- M05.____ Rheumatoid arthritis
- M06.____ Rheumatoid arthritis, unspecified
- L40.____ Psoriatic arthritis
- Other (please specify) _____

ICD-10 (Required) _____

MD Signature: _____ **NPI#:** _____ **Date:** _____

Required Documentation

Please send the following documents and records. This will help streamline the pre-authorization process.

- **If this is a continuation of a treatment, include the last infusion note**
- Patient demographic information sheet
- Copy of insurance card(s) front and back
- Copy of most recent office and consult notes (must include discussion of prescribed drug)
- Current medication list

Most recent diagnostics results to include:

- CMP/BMP
- CBC with differential
- TB test: QGT, TSpot (within 2 years) - if HX of TB or + QGT, need negative Chest Xray report sent
- Hepatitis C-Ab
- Hepatitis B-Core Ab, B SAg, B SAb

We will contact the patient and schedule their infusion appointment once we have the insurance pre-authorization completed.

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