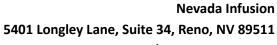


Orencia Order Form

Patient Nam	ie:		DOB:
Phone:		Address:	
			Email:
Sex:	Height:	Weight:	Allergies:
DIAGNOSIS	·.		
_	•. Imatoid Arthritis ICD-1	0. M06 0	GVHD prophylaxis ICD-10:
	articular Juvenile Idiop		
-	10:		Other: ICD-10:
	atic Arthritis ICD-10: L		
ORDER FOF	R ORENCIA (ABATAC	EPT):	
	Max dose 1000mg **	· / ·	Frequency:
•	:m	ng IV	0, 2, 4 weeks, then every 4 weeks thereafter x 1 year
	r:		Every 4 weeks x 1 year
PRE-MEDICA	ATIONS:		
	Acetaminophen 65	Omg PO	
_	Diphenhydramine 2	•	rtec 10 mg PO
	☐ Hydrocortisone 100	•	_
_		•	
ΜΔΥ ΔΠΜΙΝ	NISTER IF NEEDED FOR	ALLERGIC REACTIO	N·
_	ada Infusion Hypersen		
	er:	•	
	···		
ACCESS: Peri		DICC I'	
	ipheral IV, Port, Midlin	ie, or PICC line	
	•		ml for port – 100 units/ml
FLUSHING: 1	•		ml for port – 100 units/ml
FLUSHING: 1 NURSING: P	10 mls NS pre/post inf Per Nevada Infusion	usion OR Heparin 5	
FLUSHING: 1 NURSING: P	10 mls NS pre/post inf Per Nevada Infusion	usion OR Heparin 5	
FLUSHING: 1 NURSING: P LABS ORDER	10 mls NS pre/post inf Per Nevada Infusion	usion OR Heparin 5	
FLUSHING: 1 NURSING: P LABS ORDER PROVIDER II	10 mls NS pre/post inf Per Nevada Infusion RS:	usion OR Heparin 5	Fax results to:
FLUSHING: 1 NURSING: P LABS ORDER PROVIDER II Physician Na Physician Sig	10 mls NS pre/post infer Nevada Infusion RS: NFORMATION: ame: gnature:	usion OR Heparin 5	

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

^{**}Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **





PH: 775-453-0667 | Fax: 775-470-8478

Patient Name:	DOB:
Please Include Required Documentation for Expedited Order Processing	& Insurance Approval:
☐ Signed provider orders (page 1)	
☐ Patient demographic and insurance information	
☐ Patient's current medication list	
\square Supporting recent clinical notes and H&P (to support primary diagnosi	s)
\square Supporting documentation to include past tried and/or failed therapie	S
\square Supporting clinical notes to include any past tried and/or failed therap	ies, intolerance, benefits, or
contraindications to conventional therapy:	
\square Has the patient had a documented contraindication/intoleranc	e or failed trial of a DMARD, NSAID, or
conventional therapy (i.e., MTX, leflunomide)?	
☐ Yes OR ☐ No	
If yes, which drug(s)?	
\square Does the patient have a contraindication/intolerance or failed t	trial to at least one biologic (i.e., Humira,
Enbrel, Simponi, Cimzia)?	
☐ Yes OR ☐ No	
If yes, which drug(s)?	
\square GVHD - Will Orencia be used in combination with a calcineurin	inhibitor (i.e., cyclosporine, tacrolimus) and $% \left(\frac{1}{2}\right) =\left(\frac{1}{2}\right) \left($
methotrexate?	
☐ Yes OR ☐ No	
\square Include labs and/or test results to support diagnosis	
\square i.e., RF, anti-CCP, ESR, C-reactive protein	
\square If applicable - Last known biological therapy: and last	t date received: If patient
s switching to biologic therapies, please perform a wash out period of	weeks prior to starting Orencia.
☐ Other medical necessity:	
Additional REQUIRED Information:	
☐ Include labs and/or test results to support diagnosis	
\square TB screening test completed within 12 months - please attach results	
\square Positive OR \square Negative	
\square Hepatitis B screening test completed. This includes Hepatitis B antigen	and Hepatitis B core antibody total (not
gM) - please attach results	
☐ Positive OR ☐ Negative	

Please Fax This Form With - DEMOGRAPHICS, LABS, MEDICATION LIST and H&P: 775-470-8478

**Insurance verification/authorization is always obtained by Nevada Infusion prior to scheduling patients. **