BIOCARE INFUSION
ONCOLOGY & THERAPEUTICS

ORENCIA (ABATACEPT) INFUSION ORDERS

FAX: 470.922.3656 | **PHONE:** 470.377.6400

PATIENT INFORMATION:

Fax completed form, insurance information, and clinical documentation to 470.922.3656

Patient Name: ______________________________ DOB: __________ Phone: ____________

Patient Status: ☐ New to Therapy ☐ Continuing Therapy **Next Treatment Date:**

MEDICAL INFORMATION

Diagnosis: ☐ Rheumatoid Arthritis ☐ Polyarticular Juvenile Idiopathic Arthritis ☐ Psoriatic Arthritis
☐ GVHD prophylaxis ☐ Other: ______________________

ICD-10 Code : __________

Patient Weight: _______ lbs. (required) Allergies: ______________________________

THERAPY ORDER

Orencia Dose: __________ mg IV Other dose: ______________ ****Max dose: 1000mg****

Frequency: ☐ 0, 2, 4 weeks, and every 4 weeks thereafter x 1 year **or** ☐ Every 4 weeks x 1 year
☐ Other: ____________________________

Pre-Medication Orders: Tylenol ☐ 1000mg ☐ 500mg PO, please choose one antihistamine:
☐ Cetirizine 10mg PO ☐ Diphenhydramine 25mg PO ☐ Loratadine 10mg PO

Additional Pre-Medication Orders: ☐ Solu-Medrol ________ mg IVP
☐ Solu-Cortef ________ mg IVP
☐ Other: ________________

Lab Orders: ____________________________ **Frequency:** ☐ Monthly ☐ Other: ____________
☐ Yearly QFT TB screening (optional) ☐ Baseline HepBcAB total
Required labs to be drawn by: ☐ Biocare Infusion ☐ Referring Provider

Other: ____

Anaphylactic Reaction Orders:

- Epinephrine (based on patient weight)
  - >30kg (>66lbs): EpiPen 0.3mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
  - 15-30kg (33-66lbs): EpiPen Jr. 0.15mg or compounded syringe IM or subQ; may repeat in 5-10 minutes x1
- Diphenhydramine: Administer 25-50mg orally OR IV (adult)
- Refer to physician order or institutional protocol for pediatric dosing

Flush orders: NS 1-20mL pre/post infusion PRN and Heparin 10U/mL or 100U/mL per protocol as indicated PRN

PROVIDER INFORMATION

By signing this form and utilizing our services, you are authorizing *Biocare Infusion,* and its employees to serve as your prior authorization and specialty pharmacy designated agent in dealing with medical and prescription insurance companies, and to select the preferred site of care for the patient

Provider Name: ______________________ Signature: ______________________ Date: __________
Provider NPI: ____________ Phone: ____________ Fax: ____________ Contact Person: ______________
☐ Opt out of Biocare Infusion selecting site of care (if checked, please list site of care):

PREFERRED LOCATION

City: ________________ State: __________ *View our locations here:*

BIOCAREINFUSION.COM

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BIOCARE INFUSION
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COMPREHENSIVE SUPPORT FOR ORENCIA (ABATACEPT) THERAPY

PATIENT INFORMATION:

Patient Name: ____ DOB: ____________

REQUIRED DOCUMENTATION FOR REFERRAL PROCESSING & INSURANCE APPROVAL

☐ Include signed and completed order (MD/prescriber to complete page 1)

☐ Include patient demographic information and insurance information

☐ Include patient's medication list

☐ Supporting clinical notes to include any past tried and/or failed therapies, intolerance, benefits, or contraindications to conventional therapy

- ☐ Has the patient had a documented contraindication/intolerance or failed trial of a DMARD, NSAID, or conventional therapy (i.e., MTX, leflunomide)? ☐ Yes ☐ No
  If yes, which drug(s)? ____

- ☐ Does the patient have a contraindication/intolerance or failed trial to at least one biologic (i.e., Humira, Enbrel, Simponi, Cimzia)? ☐ Yes ☐ No
  If yes, which drug(s)? ____

- ☐ GVHD - Will Orencia be used in combination with a calcineurin inhibitor (i.e., cyclosporine, tacrolimus) and methotrexate? ☐ Yes ☐ No

☐ Include labs and/or test results to support diagnosis

- ☐ i.e., RF, anti-CCP, ESR, C-reactive protein

☐ *If applicable* - Last known biological therapy: ______________ and last date received: ______________. If patient is switching to biologic therapies, please perform a wash-out period of ___________ weeks prior to starting Orencia.

☐ Other medical necessity: ____

REQUIRED PRE-SCREENING

☐ **TB screening test completed within 12 months - attach results**
☐ **Positive** ☐ **Negative**

☐ **Hepatitis B screening test (Hepatitis B surface antigen) - attach results**
☐ **Positive** ☐ **Negative**

*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)

Biocare Infusion will complete insurance verification and submit all required documentation for approval to the patient's insurance company for eligibility. Our team will notify you if any additional information is required. We will review financial responsibility with the patient and refer him/her to any available co-pay assistance as needed. Thank you for the referral.

Please fax all information to (470) 922-3656 or call (470) 377-6400 for assistance

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