Intravene - Orencia Infusion Orders (rev 10/2018)

FAX to 434-455-5531 along with copy of insurance cards
Or CALL 434-947-3900 Ext. 2172

PATIENT INFORMATION

Name: _____
Address: _____
City: _____
State: _____ Zip Code:_____
Home Phone #:_____
Work Phone #:_____
DOB: _____SSN:_____
Height :_____Weight:_____Sex:_____
Allergies: _____

REFERRING PHYSICIAN INFORMATION

Physician Name: _____
Physician Address:_____
_____
Physician Phone:_____
Physician Fax:_____
NPI#:_____DEA#:_____
State License#:_____

****Please fax copy of insurance cards and this**
form to 434-455-5531

DIAGNOSIS: **(ICD-10 required)**

☐ _____ _____
☐ _____ _____
☐ _____ _____

PRE TREATMENT SCREENING:

Tuberculosis Screening: Date/Results of TB test_____
Hepatitis B Screening: Date/ Results:_____
Hepatitis C Screening: Date/Results:_____

PRIOR MEDICATIONS TRIED AND FAILED :

Is your patient currently taking or failed any of the following RA products?

Methotrexate---Currently Taking☐ Failed☐ Date Failed _____
Leflunamide--- Currently Taking☐ Failed☐ Date Failed_____
Sulfasalazine---Currently Taking☐ Failed☐ Date Failed_____
Humira----------Currently Taking☐ Failed☐ Date Failed_____
Prednisone------Currently Taking☐ Failed☐ Date Failed_____
Remicade-------Currently Taking☐ Failed☐ Date Failed_____
Enbrel-----------Currently Taking☐ Failed☐ Date Failed_____
Rituxan----------Currently Taking☐ Failed☐ Date Failed_____
Other_____ Currently Taking☐ Failed☐ Date Failed_____

STANDARD ORDERS:

Infuse Orencia _____mg in Normal Saline 100ml (total volume) via infusion pump over 30 minutes.
Orencia should be given at 2 and 4 weeks after the first infusion. Then every 4 weeks thereafter for 1 year. Upon completion of Orencia infusion, infuse Normal Saline 20ml to clear line.

DOSING TABlE:

Body Weight	Dose
<60 kg (<132 lbs)	500mg
60 to 100 kg (132 to 220 lbs)	750mg
>100 kg (>220 lbs)	1 gram

Anaphylactic meds and Vital Sign Monitoring per Intravene Protocol

SiGNATURE, PRESCRIBING MD:_____ **DATE:**_____