Provider Order Form

ORENCIA (ABATACEPT)

Uptiv Health

PATIENT

Full Name: _____ DOB: _____

Mobile Phone: _____ Weight: _____ ☐ lbs ☐ kg

Allergies: _____ ☐ NKDA

Patient status: ☐ New to therapy ☐ Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

DIAGNOSIS ICD-10 code (must be specified)

☐ Rheumatoid Arthritis M05. _____ ☐ Polyarticular Juvenile Idiopathic Arthritis M08. _____

☐ Psoriatic Arthritis L40. _____ ☐ Other: _____

PROVIDER

Provider Name: _____ Provider NPI: _____

Practice Name: _____ Referral Coordinator Name: _____

Practice Address: _____

Phone: _____ Fax: _____ Email: _____

PRE-MEDICATION

☐ Acetaminophen (Tylenol) PO ☐ 500 mg ☐ 650 mg ☐ 1000 mg

☐ Diphenhydramine (Benadryl) ☐ PO ☐ IV ☐ 25 mg ☐ 50 mg

☐ Methylprednisolone (Solu-Medrol) IV ☐ 40 mg ☐ 125 mg

☐ Cetrizine (Zyrtec) 10 mg PO

☐ Other:

THERAPY ADMINISTRATION

Medication	Dose	Frequency
☐ Orencia (Abatacept), IV in 100 ml 0.9% sodium chloride	☐ 500 mg ☐ 750 mg ☐ 1000 mg	☐ Induction: week 0, 2, and 4, then every 4 weeks ☐ Maintenance: every 4 weeks
☐ Orencia (Abatacept), Subcutaneous Injection	☐ 50 mg ☐ 87.5 mg ☐ 125 mg	☐ Weekly

Refills ☐ Zero ☐ 12 months ☐ _____ Order valid for 1 year unless otherwise stated. _____

☒ Infuse over 30 minutes.

☒ Flush with 0.9% sodium chloride at infusion completion.

☒ Provide nursing care per Uptiv Health Nursing Procedures, including reaction management and post-procedure observation.

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other _____ ☐ at each dose ☐ every _____

SPECIAL INSTRUCTIONS

PLEASE ATTACH THE FOLLOWING SO WE CAN MOST EFFICIENTLY PROCESS THE PATIENT'S ORDER

☐ Patient Demographics ☐ Insurance card ☐ Progress Notes supporting DX ☐ TB status results ☐ Hepatitis B status results

Provider Signature _____ Date _____