ORENCIA® Infusion Form
Pediatrics

Fax Referral To:
877-438-9380

CONTINUUM Health

PREVIOUS ADMINISTRATION

Please provide the following information: Last Infusion Date: _____ Next Infusion Date: _____

Patient Information

Patient Name: _____ DOB: _____ Sex: ◯ M ◯ F Height: _____ Weight: _____

Phone Number: _____ Email Address: _____

Allergies: _____ Is the patient Diabetic: Y ◯ N ◯ ICD-10 Code: _____

Emergency Contact: _____ Phone Number: _____

Primary Diagnosis:

_____ Juvenile Rheumatoid Arthritis with Systemic Onset
_____ Juvenile Rheumatoid Polyarthritis (seronegative)
_____ Pauciarticular Juvenile Rheumatoid Arthritis
_____ Unspecified Juvenile Rheumatoid Arthritis
_____ Other: _____

Please attach the following: 1. List of current Medications, Previous Drug Therapy History, including therapies trailed/failed and date of last administration: Agent: _____ Date: _____ Desired Washout Period: _____ weeks 2. Copy of the patient's Insurance Card 3. Clinical progress notes and H&P to support diagnosis, 4. Relevant labs including TB Screening Results and Hepatitis B Screening (including Hep B surface antigen & Hep B Core Antibody)

Physician Information

Prescribing Physician: _____ Practice Name: _____
Practice Phone: _____ Practice Fax: _____
Email: _____ Office Contact: _____
Co-managing Physician: _____ Phone/Email: _____

Medication Order

Medication: **ORENCIA® (abatacept)**
(Pediatrics > 6 y.o.)

Administer Orencia IV over 30 minutes. ***Select Dose Below*** _____ # Refills (Recommend 5)

Select	Body Weight	Dose	Number of Vials
☐	Less than 75 kg	**10mg/kg**	weight based dosing
☐	75 to 100 kg	**750 mg**	3
☐	More than 100 kg	**1000 mg**	4

☐ ***New Start:*** Following initial administration, administer on 0, 2 and 4 weeks and then every 4 weeks.
☐ ***Maintenance Dose:*** Administer every 4 weeks
☐ ***Other Orders:*** _____

Pre-Medication Orders:

☐ Acetaminophen 650 mg PO administered 30 minutes prior to infusion
*adjust to patient's needs
☐ Other: _____

Adverse Drug Reaction Protocol: Manage any adverse reaction that may occur per approved ADR Protocol.

By signing below, I certify that above therapy is medically necessary. Presriber's Signature (SIGN BELOW)
By signing this form and utilizing our services, I am also authorizing Continuum Health to serve as my prior authorization agent with medical and pharmacy insurance providers.

_____ _____
Physician's NPI# Physician's Address

_____ _____
Prescriber's Signature Date