

Patient Information

| | | | |
|---|----------------|--------------------|----------------|
| Patient Name: | | DOB: | |
| Patient Phone: | | Patient Email: | |
| NKDA | Allergies: | Weight lbs/kg: | Height: |
| Patient Status: | New to Therapy | Continuing Therapy | Therapy Change |
| Last infusion date (if applicable): | | _____ | |
| Is the patient pregnant, planning a pregnancy or nursing: | | Yes | No |
| Does the patient need interpreter services: | | Yes | No |

Provider Information

| | | | |
|----------------------------|--|-----------------------------|-------------|
| Referral Coordinator Name: | | Referral Coordinator Email: | |
| Ordering Provider: | | Provider NPI: | |
| Referring Practice Name: | | Phone: | Fax: |
| Practice Address: | | City: | State: Zip: |

ICD-10 CODE

| | | |
|--|----------------------------|--|
| M06.9 Rheumatoid arthritis | L40.50 Psoriatic Arthritis | M08.40 Polyarticular juvenile idiopathic arthritis |
| D89.813 Graft versus host disease, unspecified (aGVHD) | | Other: _____ |

Medication Order

| | | | | | |
|--|-------------------|--|----------|------------|------------------------------|
| Orencia (abatacept) IV INFUSION | Dose: | 500mg IV | 750mg IV | 1,000mg IV | 10mg/kg (maximum of 1,000mg) |
| | | Other: _____ | | | |
| | Frequency: | Initiation therapy: Administer at 0, 2 and 4 weeks then every 4 weeks thereafter | | | |
| | | Maintenance: Every 4 weeks | | | |
| | | aGVHD: Infuse over 60 minutes on the day before transplantation, followed by a dose on Day 5, 14 and 28 after transplant | | | |

| | | | | | | |
|---|--------------|---------|-----------|----------|-------------------|-------------|
| Orencia (abatacept) SC INJECTION | Dose: | 50mg SC | 87.5mg SC | 125mg SC | Frequency: | once weekly |
|---|--------------|---------|-----------|----------|-------------------|-------------|

Documentation Required (Note: Send all labs, must include specific labs listed here)

| | | | |
|---------------------|---------------------------------|---------------------|------------------------|
| Labs (TB and Hep B) | Insurance Card (front and back) | Current Medications | History/Progress Notes |
|---------------------|---------------------------------|---------------------|------------------------|

Pre-Medication Order

| | | | | | | | | |
|--------------------------------|---------|-------|--------------|---|----------|------------------|----|----|
| acetaminophen (Tylenol) | 500mg | 650mg | 1000mg PO | diphenhydramine (Benadryl) | 25mg | 50mg / | PO | IV |
| cetirizine (Zyrtec) | 10mg PO | | | methylprednisolone (Solu-Medrol) | 40mg IV | 125mg IV | | |
| loratadine (Claritin) | 10mg PO | | | hydrocortisone (Solu-Cortef) | 100mg IV | | | |
| Other: _____ | | | | | | | | |
| Dose: _____ | | | Route: _____ | | | Frequency: _____ | | |

Special Instructions (Prior therapy, treatment dates, and reasons for d/c)

| | | |
|--|------------------------------------|----------------------|
| _____ Provider Name | _____ Provider Signature | _____ Date |
| Order Expiration Date (mm/dd/yy): _____ (If not indicated order will expire one year from date signature) Check here if this is a stat order | | |

Patient Information

Patient Name: _____ DOB: _____ Sex: **M** **F**

Patient Phone: _____ Fasting: **Y** **N**

Lab Test (Please circle or write in ICD-10)

| | | | |
|---------------------------|--|---|---|
| ALT | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21 | HIV VIRAL LOAD | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20 |
| AST | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21 | IgE | J45.4, J45.3, L50.9, J45.40, J45.50 |
| HEPATIC FUNCTION PANEL | R94.5, R74.8, R79.89, K50.90, K51.90, G35, Z11.4, Z20.2, B20, Z21 | IgG | G35, G36.0 |
| BASIC METABOLIC PANEL | I10, E87.1, Z79.899, E87.5, E80.20, G35, M81.0, M81.8, N18.9 | IMMUNOGLOBULIN QUANT IgG, IgM, IgA | G35, G36.0 |
| CALCIUM | M81.0, M81.8 | IMMUNOGLOBULIN QUANT IgG, IgM, IgA, IgE | G35, G36.0 |
| CBC (INCLUDES DIFF/PLT) | I10, D64.9, Z00.00, R53.83, G35, C50.011, D70.9, D50.0, D63.1 | IRON, TIBC, FER PNL | D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9 |
| CBC (H/H, RBC, WBC, PLT)s | I10, Z00.00, Z13.0, D64.9, G35, C50.011, D70.9, D50.0, D63.1 | LIPID PANEL | Z79.899, E78.5, E55.9, E78.00, Z00.00, E78.01, E78.2 |
| COMP METABOLIC PANEL | I10, Z79.899, E78.5, E11.9, E78.2, E80.20, G35, M81.0, M81.8, N18.9 | MAGNESIUM | I10, Z79.899, R25.2, E83.42, Z00.00 |
| CREATININE | M81.0, M81.8, G35 | PSA | R97.20, C61, N40.1, Z12.5, N40.0 |
| C-REACTIVE PROTEIN (CRP) | R53.83, R79.82, M35.3, I10, M06.9, K50.90, K51.90, M32.9, L40.50 | PROTHROMBIN TIME-INR | Z79.01, I48.91, I48.0, Z51.81 |
| FERRITIN | D64.9, D50.9, D50.0, D50.8, Z00.00, D63.1, N18.9 | TRANSFERRIN SATURATION | D50.9, D64.9, D50.0, D50.8, Z00.00, D63.1, N18.9 |
| G6PD | M1A.9XX0, M1A.9XX1 | QUANTIFERON TB GOLD | Z79.899, Z00.00, Z01.84, M06.9, M08.9, M45.0, L40.0, L40.50, K51.90, K50.90 |
| GROWTH HORMONE | E22, C7A.1, E34 | TSH | E03.9, I10, E03.8, R53.83, E06.3, E05.00 |
| HBSAG CONFIRMATION | Z11.3, Z36.9, Z20.2, Z11.59, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0 | URIC ACID | M10.9, E79.0, I10, Z00.00, M1A.9XX0, M1A.9XX1 |
| HEMOGLOBIN & HEMATOCRIT | D50.9, D64.9, D50.0, D63.1, N18.9 | VIT B12/FOLIC ACID | M89.49, E53.8, R53.83, F41.8, F41.9, E05.00 |
| HEMOGLOBIN A1C | E11.9, E11.65, R73.01, Z00.00, I10 | VIT D 25- HYDROX | E55.9, Z00.00, R53.83, I10, Z79.899, M81.0, M81.8 |
| HEP B SURF AG | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, G35, K50.90, K51.90, L40.0, L40.50, M06.9, M45.0 | Miscellaneous Labs Not Listed (Write In) | |
| HIV 4TH GEN | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20 | | |
| HIV 1/2 AB DIFF | Z11.3, Z36.9, Z20.2, Z11.59, Z79.899, Z11.4, Z21, B20 | | |

Frequency

Prior to each dose Yearly Other: Please Specify Below

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Lab Test: _____ Frequency: _____

Provider Name _____ Provider Signature _____ Date _____

Provider Phone _____