IV INFUSION Treatment Center

FAX REFERRAL: **800-970-6020**

ORENCIA® (abatacept)
Injection for Intravenous Use
Injection for Subcutaneous Use

Orencia Referral Checklist

Date: ___/___/___.

Referring Physician: _____.

Physician's Telephone #: _____ Facsimile #: _____.

Patient's Name: _____ Date of Birth: ___/___/___.

- ☐ Patient Demographics
- ☐ Most Recent Office Visit Note
- ☐ Most recent PPD test. If not completed, patient can receive it at our office
- ☐ **Diagnosis:** ☐ Rheumatoid Arthritis – Please specify ICD 10 diagnosis
  - ☐ M05.7-
  - ☐ M05.69
  - ☐ M05.89
  - ☐ M05.9
  - ☐ M06.09

Dosage: Weight Based

- ☐ <60 kg – 500 mg IV Q 4 weeks
- ☐ 60-100 kg – 750 mg IV Q 4 weeks
- ☐ >100 kg – 1000 mg IV Q 4 weeks

- ☐ **Initiation regimen** IV infusion at weeks – 0, 2, 4, and Q 4 weeks thereafter
- ☐ **Maintainance regimen** IV infusion every 4 weeks

Office Staff Name: _____ Signature _____.