

Order Form

Patient Name	
DOB	
Address	
Phone	

Order Status	<input type="checkbox"/> New Order	<input type="checkbox"/> Renewal	<input type="checkbox"/> Dose or Frequency Change
Allergies:			Weight: Height:
Diagnosis	<input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Psoriatic arthritis <input type="checkbox"/> Other:	Diagnosis Code:	
Required Information (please include labs attached)	Negative Quantiferon TB, T-spot or chest x-ray (no active disease)	Date:	
	Diagnostic Hepatitis B panel	Date:	
	CBC, CMP, +RF, Anti-CCP and CRP	Date:	
Labs	<input type="checkbox"/> CBC, CMP every:	<input type="checkbox"/> Other:	

Required Documentation

- H&P or progress note supporting diagnosis and any Hx of inadequate or failed prior therapy and reasons
- Medication history
- Recent labs (as above) and/or diagnostic test results
- For RA-continuation therapy requires 20% improvement from baseline in tender joint count, swollen joint count, pain or disability
- For Articular juvenile idiopathic arthritis 2 years of age or older-continuation-documented improvement from baseline of number of joints with active arthritis, number of joints with limitation of movement or functional ability.
- For PsA-continuation of therapy requires documentation of improvement in number of swollen joints, or number of tender joints, dactylitis, enthesitis, axial disease or skin and/or nail involvement

Pre-Medications

- | | | | | |
|--|--------------------------|-----------------------------|--|------------------------------|
| <input type="checkbox"/> Diphenhydramine | <input type="radio"/> PO | <input type="radio"/> 25 mg | <input type="checkbox"/> Acetaminophen | <input type="radio"/> 325 mg |
| | <input type="radio"/> IV | <input type="radio"/> 50 mg | | <input type="radio"/> 650 mg |
| <input type="checkbox"/> Other: | | | | |

Medication Order

	IV dosing is according to body weight	Frequency
Orencia (abatacept)	<input type="checkbox"/> <60 kg: 500 mg	<input type="checkbox"/> Induction: Week 0, 2, 4, then every ____ weeks thereafter
	<input type="checkbox"/> 60 to 100 kg: 750 mg	<input type="checkbox"/> Maintenance: Every ____ weeks
	<input type="checkbox"/> >100 kg: 1000 mg	<input type="checkbox"/> Other:
	<input type="checkbox"/> Other:	

Infusion Reaction Medications

Hypersensitivity Reaction Protocol will be utilized unless otherwise specified

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax: