# Intravene - Orencia Infusion Orders (rev 10/2018)

**FAX to 434-455-5531 along with copy of insurance cards**
**Or CALL 434-947-3900 Ext. 3001**

## PATIENT INFORMATION

Name: ______________________________
Address: ______________________________
City: ______________________________
State: ______________ Zip Code: ____________
Home Phone #: ______________________________
Work Phone #: ______________________________
DOB: ____________ SSN: ____________________
Height : ________ Weight: _________ Sex: _______
Allergies: ______________________________

## REFERRING PHYSICIAN INFORMATION

Physician Name: ______________________________
Physician Address: ______________________________
______________________________
Physician Phone: ______________________________
Physician Fax: ______________________________
NPI#: ________________ DEA#: ______________
State License#: ______________________________

**Please fax copy of insurance cards and this** **form to 434-455-5531**

## DIAGNOSIS: (ICD-10 required)

☐ ______________________________ ______________________________
☐ ______________________________ ______________________________
☐ ______________________________ ______________________________

## PRE TREATMENT SCREENING:

**Tuberculosis Screening:** Date/Results of TB test______________
**Hepatitis B Screening:** Date/ Results:________________
**Hepatitis C Screening:** Date/Results:________________

## PRIOR MEDICATIONS TRIED AND FAILED :

Is your patient currently taking or failed any of the following RA products?

Methotrexate---Currently Taking ☐ Failed ☐ Date Failed ________________
Leflunamide--- Currently Taking ☐ Failed ☐ Date Failed ________________
Sulfasalazine---Currently Taking ☐ Failed ☐ Date Failed ________________
Humira----------Currently Taking ☐ Failed ☐ Date Failed ________________
Prednisone------Currently Taking ☐ Failed ☐ Date Failed ________________
Remicade-------Currently Taking ☐ Failed ☐ Date Failed ________________
Enbrel-----------Currently Taking ☐ Failed ☐ Date Failed ________________
Rituxan----------Currently Taking ☐ Failed ☐ Date Failed ________________
Other________________________ Currently Taking ☐ Failed ☐ Date Failed ________________

## STANDARD ORDERS:

Infuse Orencia __________mg in Normal Saline 100ml (total volume) via infusion pump over 30 minutes.
Orencia should be given at 2 and 4 weeks after the first infusion. Then every 4 weeks thereafter for 1 year. Upon completion of Orencia infusion, infuse Normal Saline 20ml to clear line.

## DOSING TABlE:

| Body Weight | Dose |
|---|---|
| <60 kg (<132 lbs) | 500mg |
| 60 to 100 kg (132 to 220 lbs) | 750mg |
| >100 kg (>220 lbs) | 1 gram |

**Anaphylactic meds and Vital Sign Monitoring per Intravene Protocol**

**SIGNATURE, PRESCRIBING MD:**______________________________ **DATE:**________________