



**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Phone: \_\_\_\_\_ Sex:  M  F Ht: \_\_\_\_\_ Wt: \_\_\_\_\_  lbs  kg  
 Primary Language: \_\_\_\_\_ Allergies: \_\_\_\_\_

**<ICD 10 CODE REQUIRED>**

**DIAGNOSIS & CLINICAL INFORMATION**

**ICD 10 Code (PROVIDE COMPLETE CODE)**

- M05. \_\_\_\_\_ Rheumatoid Arthritis w/Rheumatoid Factor
- M06. \_\_\_\_\_ Rheumatoid Arthritis w/o Rheumatoid Factor
- M08.3 Polyarticular Juvenile Idiopathic Arthritis
- Other: \_\_\_\_\_

**REQUIRED:** Demographics & Most Recent: H&P, clinical notes, labs, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy

**LAB RESULTS:** Include negative TB and negative Hepatitis B (if positive, provide documented medical treatment or clearance) prior to initiating therapy

**PRESCRIPTION**

**Pre-Medications**

- Acetaminophen: 650 mg PO
- Cetirizine 10 mg PO
- Dexamethasone: \_\_\_\_\_ mg IV
- Diphenhydramine: 25 mg PO
- Diphenhydramine: 25 mg IV
- Other: \_\_\_\_\_
- Acetaminophen: \_\_\_\_\_ mg PO
- Famotidine: \_\_\_\_\_ mg IV
- Loratadine 10 mg PO
- Methylprednisolone: \_\_\_\_\_ mg IV
- Ondansetron 4 mg IV

**Lab Orders**

- CBC w/diff: every \_\_\_\_\_  weeks  month
- CMP: every \_\_\_\_\_  weeks  month
- Other: \_\_\_\_\_  weeks  month

**Orencia (abatacept)**

**Loading Dose (SELECT ONE)**

- IV: (wt < 60 kg): Infuse 500 mg at weeks 0, 2, 4
- IV: (wt 60 kg – 100 kg): Infuse 750 mg at weeks 0, 2, 4
- IV: ( wt > 100 kg): Infuse 1000 mg at weeks 0, 2, 4

**Maintenance Dose (SELECT ONE)**

- IV: (wt < 60 kg): Infuse 500 mg every 4 weeks for one year
- IV: (wt 60 kg – 100 kg): Infuse 750 mg every 4 weeks for one year
- IV: (wt > 100 kg): Infuse 1000 mg every 4 weeks for one year

Is the patient on any other disease modifying therapy?  Yes  No

If yes, please note therapy and last dose: \_\_\_\_\_

**Adverse Events:** In the event of an adverse reaction occurring at Oregon Specialty Infusion clinic, OSI will utilize their adverse reactions protocol

**PRESCRIBING INFORMATION**

Prescriber Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
 Date: \_\_\_\_\_ NPI #: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Office phone #: \_\_\_\_\_ Office Fax #: \_\_\_\_\_