ORENCIA®

Please Fax Completed Form To: 888-898-9113

Please Send a Copy of The Patient's Insurance Cards (Front & Back)

PATIENT INFORMATION (Complete or Fax Existing Chart)

Name: ______________________ DOB: __________
Address: ______________________
City, State, Zip: ______________________
Phone: ____________ Alt. Phone: ____________
Email: ______________ SS#: ____________
Gender: ☐ M ☐ F Weight: ______(lbs) Ht: __________
Allergies: ______________________

PRESCRIBER INFORMATION

Prescriber Name: ______________________
State License: ______________________
NPI #: ____________ Tax ID: ____________
Address: ______________________
City, State, Zip: ______________________
Phone: ____________ Fax: ____________
Office Contact: ____________ Phone: ____________

INSURANCE INFORMATION – AND – Send a copy of the patient's prescription/insurance cards (front & back)

Primary Insurance: ______________________
Plan #: ______________________
Group #: ______________________
RX Card (PBM): ______________________
BIN: ____________ PCN: ____________

Secondary Insurance (If Applicable): ______________________
Plan #: ______________________
Group #: ______________________
RX Card (PBM): ______________________
BIN: ____________ PCN: ____________

CLINICAL INFORMATION

Primary ICD-10 Code (Please Specify Diagnosis): ______________________
Secondary ICD-10 Code (Please Specify Diagnosis): ______________________
Date of negative TB test: __________ ☐ TB test still pending, will fax results Is patient HBV negative or has been treated: ☐ Yes ☐ No
History of kidney disease: ☐ Yes ☐ No If yes, If yes, SCr: ________ GFR/CrCl: ________ History of heart failure: ☐ Yes ☐ No
Line Access: ☐ PIV ☐ Port ☐PICC ☐ Midline

ORENCIA® ORDERS

Prescription type: ☐ New start ☐ Restart ☐ Continued therapy Total Doses Received: ________ Date of Last Injection/Infusion: ________

Medication	Dose/Frequency	Refills
Rheumatoid Arthritis and Psoriatic Arthritis ☐ Orencia® (abatacept)	☐ 500mg (less than 60kg) intravenous infusion ☐ 750mg (60 to 100kg) intravenous infusion ☐ 1000mg (over 100kg) intravenous infusion ☐ Other: ______________________ ☐ Frequency: ______________________	________
Juvenile Idiopathic Arthritis ☐ Orencia® (abatacept)	☐ 10mg/kg intravenous infusion (if less than 75kg) ☐ 750mg intravenous infusion (75 to 100kg) ☐ 1,000mg intravenous infusion (over 100kg) ☐ Other: ______________________ ☐ Frequency: ______________________	________

Pre-Medication	Dose/Strength	Directions
☐ Acetaminophen	☐ 500mg	☐ Take 1-2 tablets PO prior to infusion or post-infusion as directed
☐ Cetirizine	☐ 10mg	☐ Take 1 tablet PO prior to infusion or as directed
☐ Diphenhydramine	☐ 25mg IV/PO ☐ 50mg IV/PO	☐ Take 1 tablet PO prior to infusion or as directed OR Inject contents of 1 vial IV prior to infusion or as directed
☐ Methylprednisolone	☐ 40mg ☐ 100mg ☐ 125mg	☐ Inject contents of 1 vial IV prior to infusion or as directed ☐ Other: Inject 100mg IV 30 minutes prior to infusion
☐ ____________	____________	____________

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TALIS HEALTHCARE
AN INFUSION MANAGEMENT COMPANY

ORENCIA®

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SIGNATURE

We hereby authorize Talis Healthcare LLC to provide all supplies and additional services (nursing/patient training) required to provide and deliver the medicine as prescribed in this referral.

X____ Date: ____________________

Prescriber Signature

To ensure payment by insurance carrier, please include supporting clinical documentation for specified ICD 10 Code, demographic, and insurance information along with faxed order. Initial appointment will be verified upon insurance approval.

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