

PATIENT INFORMATION

Patient Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Allergies	<input type="checkbox"/> NKDA
Date of Birth	SSN#	Weight _____	<input type="checkbox"/> kg <input type="checkbox"/> lb Date _____
Address	City	State	Zip
Phone#(home)	Work#	ORENCIA Patient ID Number	

INSURANCE INFORMATION - (PLEASE PROVIDE COPIES OF MEDICAL AND PRESCRIPTION CARDS IF AVAILABLE)

Primary Medical Insurance	Policyholder
Group #	Policy #
Phone #	
<u>Prescription Coverage</u>	
Policyholder	
Group #	Policy #
Phone #	

DIAGNOSIS INFORMATION

<input type="checkbox"/> 714.0 Rheumatoid Arthritis (RA)	<input type="checkbox"/> Other ICD 9 _____
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PREVIOUS MEDICATIONS (please answer the following)

Please indicate which of the following has this patient taken for RA:

Methotrexate
 DMARD(s) – other than methotrexate
 Humira
 Remicade
 Enbrel
 None of the listed

PRESCRIPTION INFORMATION

Medication	Dose/Quantity	Directions	Refills
<input type="checkbox"/> Orencia® (Abatacept)	500 mg for wt <60 kg (<132 lb) <input type="checkbox"/> 2 vials 750 mg for wt 60-100 kg (132-220 lb) <input type="checkbox"/> 3 vials 1 g if weight > 100 kg <input type="checkbox"/> 4 vials 250 mg in a 15 mL vial (Please fill in weight section above)	<input type="checkbox"/> Infuse IV over 30 minutes at 0, 2, and 4 weeks. (induction) Follow with a 30 minute IV Infusion every 4 weeks. <input type="checkbox"/> Infuse IV over 30 minutes every 4 weeks. (maintenance) <input type="checkbox"/> _____	
<input type="checkbox"/> Other:			
<input type="checkbox"/> Other:			

DELIVERY INSTRUCTIONS

<input type="checkbox"/> Physician's Office	<input type="checkbox"/> Other	Date Medication Needed
<input type="checkbox"/> Patient's Home	Address	
	City/State/Zip	

PHYSICIAN CONTACT INFORMATION & AUTHORIZATION

Physician Name	Office Contact	Institution
Phone	Fax	Specialty
Address	City/State/Zip	
License #	DEA #	

Physician's Signature: _____ **Date:** _____
 (required to process prescription – stamped signatures are not permissible)