

### ORENCIA IV (Abatacept) ORDER FORM

#### REFERRAL TYPE

New Referral     
  Order Renewal     
  Restart     
  Frequency Change     
  Dosage Change

#### PREFERRED LOCATION

2730 University Blvd. West | Suite 714  
Wheaton, MD 20902

14995 Shady Grove Road | Suite 250  
Rockville, MD 20850

5454 Wisconsin Avenue | Suite 600  
Chevy Chase, MD 20815

18111 Prince Philip Drive | Suite 323  
Olney, MD 20832

71 Thomas Johnson Drive  
Frederick, MD 21702

2021 K Street, NW | Suite 300  
Washington, DC 20006

3027 Javier Road | Suite 2  
Fairfax, VA 22031

#### PATIENT INFORMATION

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Email: \_\_\_\_\_  
 Address: \_\_\_\_\_ Weight: \_\_\_\_\_ KG LBS Phone: \_\_\_\_\_

#### REFERRING PHYSICIAN INFORMATION

Name: \_\_\_\_\_ NPI: \_\_\_\_\_  
 Office Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Address: \_\_\_\_\_

#### ORENCIA IV ORDER

*We do not accept off-label diagnoses, dosages, or frequencies.*

#### Dosing/Frequency:

Initial/Reloading Dose: \_\_\_\_\_ mg IV on 0, 2, 4 weeks, then every \_\_\_\_\_ weeks  
 Maintenance Dose: \_\_\_\_\_ mg IV every \_\_\_\_\_ weeks

#### Diagnosis:

L40.51—Distal interphalangeal psoriatic arthropathy  
 L40.59—Other psoriatic arthropathy  
 M05.79—Rheumatoid arthritis with rheumatoid factor of multiple sites without organ or systems involvement  
 M05.89—Other rheumatoid arthritis with rheumatoid factor of multiple sites  
 M06.09—Rheumatoid arthritis without rheumatoid factor, multiple sites  
 M06.89—Other specified rheumatoid arthritis, multiple sites

Other Diagnosis: \_\_\_\_\_ ICD-10 Code (Required): \_\_\_\_\_

Special Instructions: \_\_\_\_\_

Physicians Signature: \_\_\_\_\_ Date: \_\_\_\_\_ *(Order is Valid for One Year)*

#### REQUIRED DOCUMENTATION

#### Please fax the following documents and records:

- Patient Demographics
- Two most recent office notes (Supporting the DX and treatment ordered)
- Most recent labs that include values for:
  - CMP, CBC, HBV Surface Antigen
  - TB Screening (PPD, QFT Gold or Tspot) or recent chest x-ray
- Copy of the patient's insurance card(s) – front and back
- Medication History
- For continuation of treatment, include the last infusion note

***We will contact the patient and schedule their treatment once our benefit investigation and any prior authorizations have been completed.***