Carepoint™
A Pharmacy That Truly Cares

Orencia Enrollment Form

P: (855) 237-9112 | F: (855) 237-9113 | www.carepointrx.com

Thank You For Trusting Us With Your Patients Care.

PATIENT INFORMATION

PLEASE INCLUDE FACE SHEET & ALL INSURANCE CARDS

Patient Name ______________________ DOB ______________ Phone ____________________

Address __________________________ City, State ________________ Zip ________________

MEDICAL ASSESSMENT

DATE ______________ Height & Weight:______________ Allergies: ______________________

☐ M06.9 Rheumatoid Arthritis ☐ M08.0 Juvenile Idiopatic Arthritis ☐ Other: ______________________

TB/PPD Test? Result: ______ History of Cancer? ☐ Yes ☐ No Secondary infection? ______________________

Prior Therapies:	Reason for Discontinuation:	Appx. Start Date:	Appx. End Date:
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______
______	______	______	______

PRESCRIPTION

			Days supply/Refills:
Orencia®:	☐ 125mg Clickjet Autoinjector	☐ Inject 125 mg subcutaneously once weekly	4 weeks /_____
Orencia IV®:	☐ 250mg Vial	Infuse ☐ 500mg ☐ 750mg ☐ 1000mg at week 0, week 2 and week 4 in (100ml) 0.9% NS over 30 min Infuse ☐ 500mg ☐ 750mg ☐ 1000mg every 4 weeks in (100ml) 0.9% NS over 30 min	4 weeks /_____ 4 weeks /_____
Premedications:	☐ Acetaminophen 650mg PO ☐ Benadryl 50mg PO	☐ Sig:______________________	Quantity /Refill
Other:			_____/_____

☒ Dispense sufficient quantity of all necessary supplies (syringes, needles, alcohol wipes, etc.) for medication administration

PROVIDER

PLEASE INCLUDE ALL RECENT LABS & CLINICAL NOTES

Prescriber Name ______________________ Phone ______________ Fax ______________

______________________	(______________________)	______________________
Prescriber Signature	***NPI or DEA***	***In-Office Contact Person***

**By Signing this form and utilizing our services, you are authorizing Carepoint and it's employees to serve as your designated agent for handling*