(abatacept)

ORENCIA infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

☐ _____ Rheumatoid Arthrtisis

☐ _____ Polyarticular Idiopathic Arthritis > 6 yro (PJIA)

☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____ *(other)*

☐ Length of Need _____

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ *(other)*

ORENCIA ORDERS

DOSAGE

◯ 500mg ◯ 750mg ◯ 1000mg

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

◯ every 0,2,4, and every 4 weeks

◯ every _____ weeks

◯ Refills: _____

Notes

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Address _____

_____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887