

Borough Park
1428 36th Street
Suite 107
Brooklyn, NY 11218

Crown Heights
555 Lefferts Avenue
Brooklyn, NY 11225

Manhattan
57W 57Street
Suite 601
New York, NY 10019



Queens
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

Riverhead
1228 E Main Street
Suite A
Riverhead, NY 11901

Manhasset
333 East Shore Road
Suite 201
Manhasset, NY 11030

Rockville Centre
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

Elmsford/ Terrytown
555 Taxter Road
3rd Floor
Elmsford, NY 10523

Holbrook/ Ronkonkoma
233 Union Ave
Suite 207
Holbrook, NY 11741

Scarsdale
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583



(abatacept)

Date: _____

ORENCIA infusion orders

Patient Name _____ DOB _____

Phone _____ MO FO

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

DIAGNOSIS Please provide ICD-10 code

- _____ Rheumatoid Arthritis
- _____ Polyarticular Idiopathic Arthritis > 6 yro (PJIA) *(other)*

PRE-MEDICATION

- Tylenol 1000mg PO
- Diphenhydramine 25mg PO
- Cetirizine 10mg PO
- _____
- Solu-Medrol 125mg IVP
- Solu-Cortef 100mg IVP
- Diphenhydramine 25mg IVP
- _____

ORENCIA ORDERS

<p>DOSAGE</p> <p><input type="radio"/> 500mg <input type="radio"/> 750mg <input type="radio"/> 1000mg</p> <p>FREQUENCY</p> <p><input type="radio"/> every 0,2,4, and every 4 weeks <i>(induction)</i></p> <p><input type="radio"/> every _____ weeks</p>	<p>PATIENT WEIGHT</p> <p>_____ lbs.</p> <p>_____ kg</p>
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NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____