

(abatacept)

Date: _____

ORENCIA infusion orders

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

☐ Allergies _____

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

DIAGNOSIS Please provide ICD-10 code

- ☐ _____ Rheumatoid Arthritis ☐ _____ (other)
☐ _____ Polyarticular Idiopathic Arthritis > 6 yro (PIIA)

PRE-MEDICATION

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

ORENCIA ORDERS

DOSAGE ☐ 500mg ☐ 750mg ☐ 1000mg	PATIENT WEIGHT _____ lbs. _____ kg
FREQUENCY ☐ every 0,2,4, and every 4 weeks (induction) ☐ every _____ weeks ☐ Quant _____	☐ Refills _____

NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____