Chicago Illinois
4711 Golf Road
Suite 900
Skokie, IL 60076

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

(abatacept)

ORENCIA infusion orders

Date: _____

Patient Name _____ DOB _____

Phone _____ ○ Allergies _____ M ○ F ○

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

DOSAGE

○ 500mg ○ 750mg ○ 1000mg

FREQUENCY

○ every 0,2,4, and every 4 weeks *(induction)*

○ every _____ weeks

○ Quant_____

PATIENT WEIGHT

_____ lbs.

_____ kg

○ Refills_____

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone_____ Fax _____