Patient Name:_______________________________________

DOB:______________________ Wt(kg):_________________

Allergies:___________________ Phone:_________________

Orencia (Abatacept) Infusion Orders

Required Information:

- Signed order from prescribing provider
- Patient demographics including insurance information
- Supporting clinical documentation: Visit notes, diagnostic results
- Required Labs: TB & Hep B screening

Primary Diagnosis:

- Systemic Lupus Emphysematous(ICD-10 :__________)
- Rheumatoid Arthritis(ICD-10:___________)
- Rheumatoid Juvenile Idiopathic Arthritis (ICD-10 :________)
- Psoriatic Arthritis (ICD-10 :________)
- Other (ICD-10 :____________)

ORENCIA ORDERS

<60kg - Orencia 500mg
60kg to 100kg - Orencia 750mg
>100kg - Orencia1000mg

Date of Last Orencia: _____________

Frequency: Induction: weeks 0, 2, 4, then every 4 weeks
Subsequent: every _____ weeks

Administered per manufacturer guidelines

PRE-MEDICATIONS

PO Tylenol _____mg
PO Cetirizine _____mg
IV Solu-medrol _____mg

PO Loratadine _____mg
PO IV Diphenhydramine _____mg
PO IV Other:______________ _____mg

LABS

CBC	ESR	Uric Acid
CMP	TB Quantiferon Gold	Other:______
CRP	Hep B Core/Surface AG	Other:______

Frequency: Every Visit
Every Other Visit
One time only
Other:_____________

CPL Acct #:___________

ADDITIONAL INSTUCTIONS

Please include accommodations to be made for the patient, catheter care, prn orders, etc.

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Physician Name:	**Phone:**	**Fax:**
Physician Signature:	**NPI:**	**Date:**