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ORENCIA (ABATACEPT) INFUSION ORDERS

****REQUIRED INFORMATION****

- This signed order form from the provider
- Patient demographics & insurance information
- Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis
- TB and Hepatitis B documentation

Patient Name:	DOB:
Allergies:	Patient Phone:

- Diagnosis:** Systemic Lupus Erythematosus (ICD-10 Code: _____)
- Rheumatoid Arthritis (ICD-10 Code: _____)
- Juvenile Idiopathic Arthritis (ICD-10 Code: _____)
- Psoriatic Arthritis (ICD-10 Code: _____)

J Code: J0129

ORENCIA ORDERS

Patient Weight: _____ kg

Orencia Dose: _____ mg

Frequency: Every 4 weeks or 0, 2, 4 - Every 4 weeks

- Protocol Pre-Medication Orders:**
- Tylenol 1000mg PO
 - Cetirizine 10mg PO
 - Diphenhydramine 25mg PO
 - Loratadine 10mg PO

- Additional Pre-Medication Orders:**
- Solu-Medrol _____ mg IVP
 - Solu-Cortef _____ mg IVP

*Date of last Orencia Remicade Humira or Enbrel Dose: _____ Date: _____

Additional Instructions:

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