ORENCIA (ABATACEPT)
INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from provider
- ☐ Patient demographics & insurance information
- ☐ Clinical/Progress notes, labs, tests supporting primary diagnosis
- ☐ TB and Hep B documentation

Patient Name:	DOB:
Allergies:	Patient Phone:

Diagnosis:

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

J Code: J0129

Patient weight: _____ kg

Orencia Orders

Orencia dose: _____ mg

Frequency: ☐ Every 4 weeks ☐ 0, 2, 4 weeks then every 4 weeks

Protocol Pre-medications:
- ☐ Tylenol 1000 mg PO
- ☐ Diphenhydramine 25 mg pO

Additional Pre-medications:
- ☐ Solu-Medrol _____mg IVP
- ☐ Sou-Cortef _____ mg IVP

☐ Date of last Orencia dose: _____ or New start _____

Additional instructions:

Physician Name	Phone	Fax

Physician Signature	Date