

Los Angeles, CA
2080 Century Park East
Suite 710
Los Angeles, CA 90067



(abatacept)
ORENCIA infusion orders

Date: _____

| PATIENT INFORMATION | | |
|--|---------------------|--|
| Name: | DOB: | SEX: M <input type="checkbox"/> F <input type="checkbox"/> |
| ICD-10 code (required): | ICD-10 description: | |
| <input type="checkbox"/> NKDA Allergies: | Weight lbs/kg: | |

| REFERRAL STATUS |
|---|
| <input type="checkbox"/> New Referral <input type="checkbox"/> Referral Renewal <input type="checkbox"/> Medication/Order Change <input type="checkbox"/> Benefits Verification Only <input type="checkbox"/> Discontinuation Order |

| PHYSICIAN INFORMATION | |
|----------------------------|--|
| Referral Coordinator Name: | Referral Coordinator Email: |
| Ordering Provider: | Provider NPI: |
| Referring Practice Name: | Phone: _____ Fax: _____ |
| Practice Address: | City: _____ State: _____ Zip Code: _____ |

DIAGNOSIS *Please provide ICD-10 code*

_____ Multiple Sclerosis

_____ Polyarticular Idiopathic Arthritis > 6 yro (PJIA)

_____ _____ (other)

_____ _____ (other)

PRE-MEDICATION

| | |
|--|---|
| <input type="checkbox"/> Tylenol 1000mg PO | <input type="checkbox"/> Solu-Medrol 125mg IVP |
| <input type="checkbox"/> Diphenhydramine 25mg PO | <input type="checkbox"/> Solu-Cortef 100mg IVP |
| <input type="checkbox"/> Cetirizine 10mg PO | <input type="checkbox"/> Diphenhydramine 25mg IVP |
| <input type="checkbox"/> _____ (other) | <input type="checkbox"/> _____ (other) |

ORENCIA ORDERS

PATIENT WEIGHT

_____ lbs.

_____ kg

DOSAGE:

500mg 750mg 1000mg

Frequency:

Every, 0,2,4, and every 4 weeks (induction)

Every _____ weeks

Quant _____

Total dosage /refills _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____