**Connecticut**
500 W Putnam Ave
Ste 435
Greenwich, CT 06830

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

(abatacept)

# ORENCIA infusion orders

**Date:** ____________________

## PATIENT INFORMATION

| Name: | DOB: | SEX: M ☐ F ☐ |
|---|---|---|
| ICD-10 code (required): | ICD-10 description: | |
| ☐ NKDA Allergies: | | Weight lbs/kg: |

## REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ 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

☐ Tylenol 1000mg PO
☐ Diphenhydramine 25mg PO
☐ Cetirizine 10mg PO
☐ ________________________ *(other)*

☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ ________________________ *(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 ______________