

Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830



(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 <i>Please provide ICD-10 code</i> ☐ _____ Multiple Sclerosis ☐ _____ Polyarticular Idiopathic Arthritis > 6 yro (PJIA) ☐ _____ (other) ☐ _____ (other) PRE-MEDICATION <table border="0"><tr><td>☐ Tylenol 1000mg PO</td><td>☐ Solu-Medrol 125mg IVP</td></tr><tr><td>☐ Diphenhydramine 25mg PO</td><td>☐ Solu-Cortef 100mg IVP</td></tr><tr><td>☐ Cetirizine 10mg PO</td><td>☐ Diphenhydramine 25mg IVP</td></tr><tr><td>☐ _____ (other)</td><td>☐ _____ (other)</td></tr></table>	☐ Tylenol 1000mg PO	☐ Solu-Medrol 125mg IVP	☐ Diphenhydramine 25mg PO	☐ Solu-Cortef 100mg IVP	☐ Cetirizine 10mg PO	☐ Diphenhydramine 25mg IVP	☐ _____ (other)	☐ _____ (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 _____
☐ Tylenol 1000mg PO	☐ Solu-Medrol 125mg IVP								
☐ Diphenhydramine 25mg PO	☐ Solu-Cortef 100mg IVP								
☐ Cetirizine 10mg PO	☐ Diphenhydramine 25mg IVP								
☐ _____ (other)	☐ _____ (other)								

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____