

Borough Park 1428 36th Street Suite 107 Brooklyn, NY 11218	Forest Hills 64-05 Yellowstone Blvd CF104 Forest Hills, NY 11375	E 56th & Park Midtown 120 East 56 Street Suite 300 New York, NY 10022	NYC E 70th St Upper East Side 225 E 70th Street Suite 1E New York, NY 10021	ThrIVewell I N F U S I O N Office: 212-803-3339 Fax : 646-768-8600	Tarrytown 555 Taxter Road 3rd Floor Elmsford, NY 10523	Southampton 625 Hampton Road Southampton, NY 11968	Manhasset 333 East Shore Road Suite 201 Manhasset, NY 11030
Sheepshead Bay 2546 East 17th Street Fl. 1 Brooklyn, NY 11235	Long Island City 36-36 33rd Suite 311 Long Island City, NY 11106	FIDI 30 Broad Street Suite 401 New York, NY 10004	Central Park West 115 Central Park West Suite 15 New York, NY 10023	Port Jefferson 12 Medical Drive Suite B Port Jefferson Station, NY 11776	Riverhead 1228 E Main Street Suite A Riverhead, NY 11901	Rockville Centre 165 North Village Avenue Suite 133 Rockville Center, NY 11570	
Bronx 226 West 238th Street Bronx, NY 10463	Massapequa 97 Grand Avenue Massapequa, NY 11758	Gramercy 7 Gramercy Park West Lower Level New York, NY, 10003	Mission Medical	Staten Island 27 New Dorp Lane Staten Island, NY 10306	Holbrook 233 Union Avenue Suite 207 Holbrook, NY 11741	New Hyde Park 1991 Marcus Ave Suite 110 Lake Success, NY, 11042	Woodbury 7600 Jericho Tpk, Lower Level, Suite C500 Woodbury NY 11797

(abatacept)
ORENCIA infusion orders

Date: _____

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

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 _____

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____