

TN
100 Covey Drive
Suite 307
Franklin, TN 37067



(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

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 _____