(abatacept)

ORENCIA infusion orders

Patient Name _____ DOB _____

Phone _____ M F

DIAGNOSIS *Please provide ICD-10 code*

- ☐ _____ Rheumatoid Arthritis
- ☐ _____ Polyarticular Idiopathic Arthritis > 6 yro (PJIA)
- ☐ _____ _____ *(other)*

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____

ORENCIA ORDERS

DOSAGE

500mg 750mg 1000mg

PATIENT WEIGHT

_____ lbs.

_____ kg

FREQUENCY

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

every _____ weeks

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

v1.6 Copyright 2018, Intellectual Property of WeInfuse, LLC