Phone: (805) 719-3700
Fax: (805) 413- 9099
Website: infusionforhealth.com

ORENCIA ORDER
(Abatacept)

Please fax a copy of patient's:

- □ **Demographics**
- □ **Current Lab Results**
- □ **TB Labs**
- □ **Hep B Labs**
- □ **Copy of Insurance Cards**
- □ **Medication List**
- □ **H & P Relevant to the Diagnosis**

Date: ____/____/____

Patient Name: _____ DOB: ____/____/____

Allergies: _____ Wt: _____ lbs / kg Ht:_____

Diagnosis: _____ ICD-10: _____

TB TEST / CHEST X-RAY Result & Date : _____ ☐ COPY ATTACHED

HEP B Result & Date: _____

PRE-MEDICATIONS: (Usually not indicated)

Diphenhydramine	**☐ 25 mg**	**☐ 50 mg**	**☐ PO**	**☐ IV**	**☐ Pre-med**	**☐ PRN**
Acetaminophen	**☐ 650 mg**		**☐ PO**		**☐ Pre-med**	**☐ PRN**

Orencia (Abatacept) IV Dosage

☐ 500 mg (<60 kg) ☐ 750 mg (60-100 kg) ☐ 1 gram (>100kg) ☐ Other: _____

Frequency: ☐ Initial dose on days 1, 15, 29 then ☐ q 4 weeks

Duration: _____

Printed Provider's Name: _____ NPI: _____

Provider's Signature: _____ Date:_____/_____/_____

Office Phone Number: _____ Office Fax:_____

Office Address: _____Contact Person: _____