# Orencia Order
## (Abatacept)

Ph: 805-719-3700 | Fax: 805-852-2636

Date: ______ / ______ / ________  Treatment Location: ______________________________

***Please fax a copy of the following patient information:**
☐ Demographics ☐ Insurance Information ☐ Current Lab Results
☐ H & P Relevant to the Diagnosis and Rx ☐ Current Medications
☐ TB Labs ☐ Hep B Labs

## PATIENT INFORMATION

Patient Name: ______________________________

DOB: ______ / ______ / ________

Allergies: ______________________________

Weight: __________ lbs / kg  Height: __________

Diagnosis: ______________________________

ICD-10: ______________________________

## PROVIDER INFORMATION

Printed Provider's Name: ______________________________

Signature: ______________________________

NPI: ____________ Date: ______ / ______ / ________

Phone: (______) ______ - ______  Fax: (______) ______ - ______

Office Address: ______________________________

Contact Person: ______________________________

## TB TEST / CHEST X-RAY

Result: ____________________  Test Date: ______ / ______ / ________  ☐ Copy Attached

Hep B Result: ____________________  Test Date: ______ / ______ / ________

## PRE-MEDICATIONS: (USUALLY NOT INDICATED)

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

## ORENCIA (ABATACEPT) IV DOSAGE:

**Dose:** ☐ **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: ____________________

Revised 12/01/20