(abatacept)

ORENCIA infusion orders

Evansville Multi-Specialty Clinic

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 _____

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