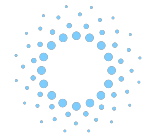


Fax: 614-929-7199/ Phone: 614-929-3349/ Email: Info@infuseoneohio.com
(abatacept)



INFUSE ONE

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

(other)

(other)

ORENCIA ORDERS

DOSAGE			PATIENT WEIGHT
500mg	750mg	1000mg	lbs.
FREQUENCY			kg
every 0,2,4, and every 4 weeks			
every	weeks		

NOTES

ORDERING PROVIDER

Signature X _____ Date _____

Provider

Phone

Fax