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 Arthrtisis

☐ _____ Polyarticular Idiopathic Arthritis > 6 yro (PJIA)

☐ _____ _____ *(other)*

PRE-MEDICATION

☐ Tylenol 1000mg PO

☐ Diphenhydramine 25mg PO

☐ Cetirizine 10mg PO

☐ _____ *(other)*

☐ Solu-Medrol 125mg IVP

☐ Solu-Cortef 100mg IVP

☐ Diphenhydramine 25mg IVP

☐ _____ *(other)*

ORENCIA ORDERS

DOSAGE

☑ 500mg ☐ 750mg ☐ 1000mg

FREQUENCY

☐ every 0,2,4, and every 4 weeks

☐ every _____ weeks

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____