

ORENCIA (abatacept) Infusion Orders

Patient Name: _____ DOB: _____ ☐ M ☐ F

☐ NKDA Allergies: _____

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider: _____ Provider NPI: _____

Practice Phone: _____ Practice Fax: _____

Diagnosis *(please provide ICD-10 code):*

☐ _____ Rheumatoid Arthritis (RA) ☐ _____ *(other)*
☐ _____ Polyarticular Idiopathic Arthritis >6 yo (PJIA)

Pre-Medication:

☐ Tylenol 1000mg PO ☐ Solu-Medrol 125mg IVP
☐ Cetirizine 10mg PO ☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg PO ☐ Diphenhydramine 25mg IVP
☐ Other: _____

Required Documents:

☒ Patient Demographic Sheet
☒ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*
☒ TB Status & Date *(please attach results)*
☒ HepB Status & Date *(please attach results)*

ORENCIA ORDERS:

Dosing: ☒ Mix in 100ml 0.9% sodium chloride, administer IV over 30 minutes

☐ 500mg ☐ 750mg ☐ 100mg ☐ Other: _____

Frequency:

☐ Every 0, 2, 4, and every 4 weeks ☐ Every _____ weeks ☐ Other: _____

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☒ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: _____ Date: _____