

(abatacept)

# 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

**ORENCIA ORDERS**

<b>DOSAGE</b>			<b>PATIENT WEIGHT</b>		
500mg	750mg	1000mg		lbs.	
				kg	
<b>FREQUENCY</b>			<b>HEIGHT</b>		
every 0,2,4, and every 4 weeks <i>(induction)</i>				ft	in
every		weeks			

**NOTES**

**ORDERING PROVIDER**

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider

Phone

Fax