CIVIC INFUSION

FAX: 203-724-4838

249 Danbury Rd, Wilton, CT 06897
400 Columbus Ave, Valhalla, NY 10595
127 Washington Ave, N. Haven, CT 06473
_____

(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

DOSAGE

○ 500mg ○ 750mg ○ 1000mg

FREQUENCY

○ every 0,2,4, and every 4 weeks *(induction)*
○ every _____ weeks

PATIENT WEIGHT

_____ lbs.
_____ kg

HEIGHT _____ ft _____ in

NOTES

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

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