



Orencia® (abatacept) Order Form

Please include the following (required):

- 1. Patient Demographics & Insurance Information
- 2. Clinical/Progress Notes, Labs, Tests supporting primary diagnosis (ICD-10)
- 3. TB screening and Hepatitis B vaccine or testing documentation.

Patient Name

DOB

Allergies

Patient Phone

Diagnosis

- Rheumatoid Arthritis: _____
- Juvenile Idiopathic Arthritis: _____
- Psoriatic Arthritis: _____
- Other (ICD-10 Code): _____

Prescription Orders: Orencia® (abatacept) 250 mg per vial

****0.2 micron filter must be used during infusion****

Initial Dosing: Infuse Orencia _____mg in NS 0.9% over 30 minutes at weeks 0, 2 and 4, then every 4 weeks

Renewal: Orencia _____mg every 4 weeks

Premedications: Acetaminophen 650 mg PO Benadryl 25 mg IVP
 Zofran 4 IVP Solu-Medrol 40 mg IVP Other _____

Lab Orders: CMP CBC ESR CRP Other: _____ every infusion

Refills: 12 months or _____ infusions

Physician Name

Phone

Fax

Physician's signature

Date

Fax completed form to (214) 887-0436. For insurance questions call (214) 276-5642.

For any other questions please call (469) 480-9649.

Or visit us online at www.ntinfusioncenters.com