NORTH TEXAS INFUSION CENTERS

# 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

**Premedication:** ☐ 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 ☐ every other infusion

**Refills:** ☐ 12 months or ☐ for _____ infusions

_____
**Provider Name** **Phone** **Fax**

_____
**Provider'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**