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 _____
☐ Polyarticular juvenile rheumatoid arthritis, acute _____
☐ Polyarticular juvenile rheumatoid arthritis, chronic or unspecified _____
☐ Other (ICD-10 Code):_____

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

Initial Dosing: Infuse Orencia _____mg in NS 0.9% (250ml) over 30 minutes at weeks 0, 2 and 4 weeks, 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 ☐ _____ infusions

_____
Physician Name **Phone** **Fax**

_____
Physician's signature **Date**

Fax completed form to (214) 887-0436.Contact us directly at: (214) 276-5642.
Or visit us online at www.ntinfusioncenters.com

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