Infusion Associates
3230 Eagle Park NE, Suite 101
Grand Rapids, MI 49525
Phone: 616-954-0600 Fax: 616-954-1675

Orencia (*abatacept*) IV Infusion ORDER

***Please fax a copy of patient's Demographics, Insurance information, Current Lab Results, H&P, and Current Medications*

Date: _____/_____/_____

Patient Name: _____ **DOB**: _____/_____/_____

Allergies: _____ **Patient Weight:** _____lbs / kg **Height:**_____

Diagnosis:_____

DX CODES: ***ICD-10*** : **_____, _____, _____, _____**

TB verification ***(circle one):*** **TB skin test** **TB spot/Quantiferon blood test** **Chest X-RAY**
□ **COPY ATTACHED**

Result Date: _____/_____/_____ Result ***(circle one):*** **Positive** **Negative**

LABS to be drawn: □ **CBC**
□ Other: _____

Lab Frequency: _____

Orencia IV Dosage:

(*abatacept*)

□ **500mg** (<60kg) □ **750mg** (60-100kg) □ **1000mg** (>100kg) □ **Other: _____**

Frequency: □ **Initial Dose** (**DAY 0, DAY 14, DAY 28 THEN EVERY 4 WEEKS).**

□ **Every 4 weeks**

INFUSE ORNECIA OVER 30 MINUTES

Start Date of Infusion: _____/_____/_____ **Orencia Infusion # _____**

Rx Expiration Date: _____/_____/_____

Printed Provider's Name: _____

Provider's Signature: _____

Office Contact Name:_____Phone#_____Fax#_____