vitalcare® of CENTRAL MISSISSIPPI

Fountains Infusion Center

159 Fountains Blvd. Madison, MS
39110 Phone: 601.859.8200 Fax:
601.859.8201

ORENCIA (ABATACEPT) INFUSION ORDERS

****REQUIRED INFORMATION****

- ☐ This signed order form from the provider
- ☐ Patient demographics & insurance information
- ☐ **Clinical/Progress Notes, Labs, Tests** supporting primary diagnosis
- ☐ TB and Hepatitis B documentation

Patient Name:	**DOB:**
Allergies:	**Patient Phone:**

Diagnosis: ☐ Systemic Lupus Erythematosus (ICD-10 Code: _____)
☐ Rheumatoid Arthritis (ICD-10 Code: _____)
☐ Juvenile Idiopathic Arthritis (ICD-10 Code: _____)
☐ Psoriatic Arthritis (ICD-10 Code: _____)

J Code: J0129

ORENCIA ORDERS

Patient Weight: _____kg

Orencia Dose:_____mg

Refills:_____

Frequency: ☐ Every 4 weeks or ☐ 0, 2, 4 - Every 4 weeks

Protocol Pre-Medication Orders:
☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Loratadine 10mg PO

Additional Pre-Medication Orders:
☐ Solu-Medrol _____mg IVP
☐ Solu-Cortef _____mg IVP

Required labs to be drawn by: ☐ Infusion Center ☐ Referring Physician

Lab orders: _____ **Frequency:** _____

Additional Instructions:

Physician Name:	**Phone:**	**Fax:**
****Physician Signature:**	**Date:**	