RESTORE HEALTH
INFUSION AND WELLNESS

ORENCIA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ **DOB**: _____ **Gender**: ☐M ☐F ☐Other _____

Phone: _____ **Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

PRESCRIBER INFORMATION

Prescriber Name: _____ **DEA:** _____ **NPI:** _____ **State License:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone: _____ **Fax:** _____

CLINICAL INFORMATION

Diagnosis: ☐M05.___ (Rheumatoid Arthritis w/ RF) ☐M06.___ (Rheumatoid Arthritis w/o RF)
☐L40.5 (Arthropathic Psoriasis) ☐Other: _____ ☐

Allergies: _____ **Weight**: _____ ☐Kg ☐Lbs **Height:** _____ ☐ cm ☐ in

TB/PPD test: ☐Positive ☐ Negative **HBV**: ☐Yes ☐No If yes, treated: ☐ Yes ☐No

TREATMENT INFORMATION

ORENCIA (abatacept)

Route: Intravenous infusion

Dose: ☐500mg (<60kg) ☐750mg (60-100kg)
☐1000mg (>100kg) ☐ Other: _____ mg

Frequency:

☐ Induction: Once in weeks 0, 2, and 4

☐ Maintenance: Every 4 weeks

Quantity: _____ **Refills:** _____

Premedication Protocol: *(Not Usually Recommended)*

☐ Diphenhydramine: ☐25mg ☐50mg ☐PO ☐IV

☐ Acetaminophen: ☐325mg ☐500mg ☐650mg PO

☐ Other: _____

Sig: _____

Special Instructions: _____

Provider Name: _____ Provider Signature: _____ Date: _____