vitalcare® INFUSION SERVICES of SIOUX FALLS

1020 S Cliff Ave., Sioux Falls, SD 57104
P / 605-220-7824 · F / 605-220-7980
www.vitalcaresiouxfalls.com

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

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

*Date of last ☐ Orencia ☐ Remicade ☐ Humira or ☐ Enbrel Dose:_____ Date:_____

Additional Instructions:

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