LifeCare INFUSION

6415 Fort Apache Road, Suite #175
Las Vegas, NV 89148
Phone: 702-665-5730
Fax: 702-780-4887

Orencia (abatacept) **Infusion Orders**

Patient Name: _____ Date of Birth: _____
Address: _____ Phone Number: _____
Gender: _____ Height: _____ Weight: _____ (lb/kg)

Diagnosis

☐ _____ Rheumatoid Arthritis
☐ _____ Polyarticular Idiopathic Arthritis > 6yro (PJIA)
☐ _____

Pre-Medication

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Solu-Medrol 125 IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ _____
☐ _____

Orders

Dosage
☐ 500mg
☐ 750mg
☐ 1000mg
Frequency
☐ every 0, 2, 4, and every 4 weeks
☐ every _____ weeks _____ Refills

Notes

_____
_____
_____
_____
_____

Ordering Provider

Signature: _____ Date: _____
Provider: _____ Phone: _____ Fax: _____
Address: _____
NPI: _____ DEA: _____