ORENCIA
(abatacept)

FLOURISH™ HEALTH GROUP

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

- Insurance Card
- History & Physical
- Patient Demographics
- Most Recent Labs
- Medication List
- MRI Results
- Negative TB Results
- Hepatitis Panel

PRIMARY DIAGNOSIS

☐ ICD-10 (_____)
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ Other:_____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

Please list any labs to be drawn by the infusion clinic: _____

_____

PRE-MEDICATIONS

☑ Per infusion clinic protocol: No recommended standard pre-meds for Orencia
☐ Provider Prescribed: _____

_____

PRIMARY MEDICATION ORDER

☐ (weight <60kg) Orencia 500mg IV at week 0, 2, 4, and every 4 weeks thereafter
☐ (60-100kg) Orencia 750mg IV at week 0, 2, 4, and every 4 weeks thereafter
☐ (weight > 100kg) Orencia 1000mg IV at week 0, 2, 4 and every 4 weeks thereafter
☐ Orencia_____mg IV every_____weeks
☐ Other:_____

First Dose: ☐ Y ☐ N ☑ Refill x12 months unless otherwise noted:_____

LINE USE/CARE ORDERS

☑ Start PIV/ACCESS CVC ☑ Flush device per Flourish Health Group's protocol (See flourishhealth.com for detailed policy)
☐ Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion reaction and anaphylaxis medications per Flourish Health Group's protocol
(See flourishhealth.com for detailed policy)

☐ Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	☐ Fax:
NPI **AND** License:	☐ Email:

_____ _____
Provider Signature Date