NEW ENGLAND
Cancer Specialists
Infusion Center
Kennebunk · Portsmouth · Scarborough · Topsham
Phone: 207-303-3225 Fax:207-692-2473

Orencia (Abatacept) Order Form – J0129

Patient Name:_____ **DOB:**_____

Diagnosis: _____ Diagnosis Code:_____

Height: _____(cm) Actual Weight: ____(kg) Allergies: _____

Please list any premeds needed here:_____

***Required labs: TB and HBV prior to therapy initiation**

Orencia dosing: Psoriatic arthritis and Rheumatoid athritis: **check all boxes that apply**

☐ **IV <60kg=500mg** ☐ **Initial** ☐ **day 15** ☐ **every 4 weeks.**

☐ **IV 60kg-100kg=750mg** ☐ **Initial** ☐ **day 15** ☐ **every 4 weeks.**

☐ **IV >100kg=1000mg** ☐ **Initial** ☐ **day 15** ☐ **every 4 weeks.**

Orders valid through___/___/___

- **In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: _____

Provider Signature: _____ Date: _____

Phone: _____ Fax: _____ Pager: _____