NEW ENGLAND
Cancer Specialists

Infusion Center

KENNEBUNK | ROCK ROW | TOPSHAM | PORTSMOUTH
PHONE: (207) 303-3225 | FAX: (207) 692-2473

Orencia (Abatacept) Order Form–J0129

Patient Name | Middle | Last | DOB

Diagnosis | Diagnosis Code

Height (cm) | Actual Weight (kg) | Allergies

Please list any premeds needed.

*Required labs: TB and HBV prior to therapy initiation

ORENCIA DOSING: PSORIATIC ARTHRITIS AND RHEUMATOID ATHRITIS: *CHECK ALL BOXES THAT APPLY*

- ◯ IV <60 kg=500 mg ◯ Initial ◯ Day 15 ◯ Every 4 weeks
- ◯ 60 kg-100 kg=750 mg ◯ Initial ◯ Day 15 ◯ Every 4 weeks
- ◯ IV >100 kg=1,000 mg ◯ 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