

Orencia (Abatacept)

PATIENT INFORMATION

Referral Status (check one): New Referral Updated Order Order Renewal

Patient Name: _____ DOB: _____

NKDA Allergies: _____ Weight _____ Please specify: lbs kg Height: _____

Patient Status (check one): New to Therapy Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

TB status & date (list results here & attach clinicals)

PRE-MEDICATION ORDERS

acetaminophen (Tylenol) 500mg | 650mg | 1000mg PO
 cetirizine (Zyrtec) 10mg PO
 loratadine (Claritin) 10mg PO
 diphenhydramine (Benadryl) 25mg | 50mg | PO | IV
 methylprednisolone (Solu-Medrol) 40mg | 125mg IV
 hydrocortisone (Solu-Cortef) 100mg IV
 Other: _____
 Dose: _____ Route: _____
 Frequency: _____

THERAPY ADMINISTRATION

Abatacept (Orencia) in 100ml 0.9% sodium chloride, intravenous infusion over 30 minutes (use in line filter 0.2 to 1.2 micron)

- Dose: 500mg / 750mg / 1000mg / _____ mg
- Frequency: induction: week 0, 2, and 4, then every 4 weeks / maintenance: every 4 weeks / other: _____

Route: intravenous

- Infuse over 30 minutes
- Remove equal volume from bag prior to adding medication
- Flush with 0.9% sodium chloride at infusion completion

Abatacept (Orencia) injection

- Dose: 50mg / 87.5mg / 125mg
- Frequency: weekly / other: _____
- Route: subcutaneous

Patient is required to stay for 30-minute observation

Refills: Zero / for 12 months / _____
 (if not indicated order will expire one year from date signed)

* Screen for latent TB infection prior to initiating therapy. Patients testing positive should be treated prior to initiating ORENCIA.

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
 Ordering Provider: _____ Provider NPI: _____
 Referring Practice Name: _____ Phone: _____ Fax: _____
 Practice Address: _____ City: _____ State: _____ Zip Code: _____

 Provider Name (Print)

 Provider Signature

 Date