

# Orencia (Abatacept)

Provider Order Form rev. 4/10/2022

## 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)
- Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

### 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