Abatacept (Orencia)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION **Referral Status:** ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS ***(Please provide ICD-10 code in space provided)***

Psoriatic Arthritis: Rheumatoid Arthritis:

Other: Description:

THERAPY ADMINISTRATION

☑ Administer Abatacept (Orencia) _____ mg IV in 100 mL 0.9% sodium chloride over a period of 30 minutes

DOSING *(Choose one)*

☐ Less than 60 kg: 500 mg
☐ 60-100kg: 750mg
☐ Greater than 100kg: 1000mg

FREQUENCY *(Choose one)*

☐ Induction: On Week 0, Week 2, Week 4, then every 4 weeks
☐ Maintenance: Every 4 weeks
☐ Every _____ weeks

ADDITIONAL ORDERS

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:
- Signs or symptoms of illness or active infection.
- Planned/recent surgical procedures or recent live vaccinations.
- Positive Hepatitis B or TB lab results (must have prior to start).

☑ Record vital signs before and after infusion.
☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications with MTX, biologic agents and steroids, Colonoscopy or BSA of affected skin
Required Labs: TB, Hep B, CRP, ESR For RA: Rheumatoid factor, CCP. For CD/UC: Fecal Calpro

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.