ABATACEPT (ORENCIA®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

option care health™

Patient Name:			**Date of Birth:**	
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:	**ICD-10 Code:**

Is this the first dose?	☐ Yes – date of first dose: ☐ No – date of next dose due:	**Hepatitis B Status:**	Titer Date: ☐ Positive ☐ Negative

TB Status:	☐ PPD (negative) – date: ☐ Last chest x-ray – date: ☐ Past positive TB infection, course taken:	☐ Active TB ☐ Unknown

Abatacept (Orencia®) Prescription

Abatacept (Orencia®) refill as directed x 1 year

Initial Dose:
- ☐ Infuse 500 mg IV over 30 minutes on Weeks 0, 2, and 4 (patient weight < 60 kg)
- ☐ Infuse 750 mg IV over 30 minutes on Weeks 0, 2, and 4 (patient weight 60 to 100 kg)
- ☐ Infuse 1000 mg IV over 30 minutes on Weeks 0, 2, and 4 (patient weight > 100 kg)
- ☐ Other: _____

Maintenance Dose:
- ☐ Infuse 500 mg IV over 30 minutes every 4 weeks (patient weight < 60 kg)
- ☐ Infuse 750 mg IV over 30 minutes every 4 weeks (patient weight 60 to 100 kg)
- ☐ Infuse 1000 mg IV over 30 minutes every 4 weeks (patient weight > 100 kg)
- ☐ Other: _____

Ancillary Orders

Anaphylaxis Kit

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- Normal saline 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis. Patients ≤ 30 kg, infuse over 2 to 4 hours PRN headache rated > 5 on pain scale.

Medication Orders
- ☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may decline.
- ☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.
- ☐ Methylprednisolone 40 mg IV push 20 minutes prior to infusion.
- ☐ Other: _____

IV Flush Orders
- ☐ Peripheral: NS 2 to 3 mL pre-/post-use.
- ☐ Implanted Port: NS 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders
- ☐ No labs ordered at this time.
- ☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:	**Phone:**	**Fax:**
Address:	**NPI:**	
City, State: **Zip:**	**Office Contact:**	

