

ABATACEPT (ORENCIA®) PRESCRIBER ORDER FORM

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



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: Active TB Last chest x-ray – date: Unknown Past positive TB infection, course taken:**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:

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