

# Abatacept (Orencia)

Fax to 505-420-4848 or Email to refer@optimuminfusion.com



## PATIENT INFORMATION

Referral Status:  New Referral  Updated Order  Order Renewal

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

ICD-10 code (required): \_\_\_\_\_ ICD-10 description: \_\_\_\_\_

NKDA Allergies: \_\_\_\_\_ Weight (lbs/kg): \_\_\_\_\_ Height: \_\_\_\_\_

Patient Status:  New to Therapy  Continuing Therapy Last Treatment Date: \_\_\_\_\_ Next Due Date: \_\_\_\_\_

## PROVIDER INFORMATION

Referral Coordinator Name: \_\_\_\_\_ Referral Coordinator Email: \_\_\_\_\_

Ordering Provider: \_\_\_\_\_ Provider NPI: \_\_\_\_\_

Referring Practice Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Practice Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## NURSING

- TB status & date (list results here & attach clinicals)  
\_\_\_\_\_
- Hepatitis B status & date (list results here & attach clinicals)  
\_\_\_\_\_
- Provide nursing care per Optimum Infusion Nursing Procedures, including reaction management and post-procedure observation

## LABORATORY ORDERS

- CBC  at each dose  every \_\_\_\_\_
- CMP  at each dose  every \_\_\_\_\_
- CRP  at each dose  every \_\_\_\_\_
- Other: \_\_\_\_\_

## 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
- 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)

## SPECIAL INSTRUCTIONS

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

Provider Name (Print)

Provider Signature

Date

### SUBMIT ORDER FORM TO OPTIMUM INFUSION:

- FAX: 505-420-4848
- EMAIL: refer@optimuminfusion.com