Abatacept (Orencia®)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVe Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

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Patient Name: _____

Patient Address: _____

Patient Phone Number: _____

Date of Birth: ____/____/____

Weight: _____kg **Height:** _____cm

Allergies: _____

Primary Insurance: _____

Member ID: _____

Secondary Insurance: _____

Member ID: _____

Diagnosis

Diagnosis Code (ICD-10): _____

Indication: _____

Target start date: _____

Labs

No labs required. Labs to be ordered by physician.

☐ CBC

☐ Other: _____

Date of negative Tuberculosis Screen: _____   **Date of Negative Hepatitis Screen:** _____

Hold and notify provider: Patient has signs/symptoms of an active serious infection.

Abatacept (Orencia®) in 100mL 0.9% sodium chloride

Induction Dose:

☐ < 60 kg: Infuse 500 mg IV over 30 minutes on Weeks 0, 2, and 4

☐ 60 to 100 kg: Infuse 750 mg IV over 30 minutes on Weeks 0, 2, and 4

☐ > 100 kg: Infuse 1,000 mg IV over 30 minutes on Weeks 0, 2, and 4

☐ Other: _____

Maintenance Dose: Every 4 weeks x 1 year (beginning 4 weeks after last induction dose)

☐ < 60 kg: Infuse 500 mg IV over 30 minutes every 4 weeks

☐ 60 to 100 kg: Infuse 750 mg IV over 30 minutes every 4 weeks

☐ > 100 kg: Infuse 1,000 mg IV over 30 minutes every 4 weeks

☐ Other: _____

Note to nurse: Administer with 0.2 - 1.2 micron low-protein binding filter. NS flush only.

Pre-Medications and Pre-Protocol (ordered at physician discretion)	☐ Acetaminophen 650 mg PO once
	☐ Loratadine 10 mg PO once
	☐ Diphenhydramine once
	  ☐25 mg ☐50 mg
	  ☐ PO ☐IV
	☐ Famotidine 20 mg IV once
	☐ Hydrocortisone 100 mg IV once
	☐ Methylprednisolone 125 mg IVP once
	☐ Other: _____
		Hydration
		☐ LR
		☐ Sodium Chloride 0.9%
		☐ Other _____
		
		_____ mL at _____mL/hr
		☐ Before ☐ During ☐ Following

ArrIVe
INFUSION THERAPY

An Outpatient Department of Trinity Health Oakland
9400 Village Place Blvd, Brighton, MI 48116
Phone: 810-844-7373
Fax: 810-844-7366

Flushing Protocol (pre and post medication)	☐ Sodium Chloride 0.9% ☐ 5 mL ☐ 10 mL as needed for line care	☐ Heparin _____Units/mL _____mL as needed for line care
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	• **Sodium chloride** 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • **Acetaminophen** 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • **Albuterol** 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • **Albuterol HFA** inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • **Epinephrine** injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • **Famotidine** injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • **Diphenhydramine** injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • **Diphenhydramine** injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • **Hydrocortisone** sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure
Provider Name: _____ Attending Physician Name: _____ Office Phone Number: _____ *(If ordering provider is an advanced practice practitioner)* *Note: This order is valid for 12 months from date of physician signature.*	Provider Signature: _____ Provider NPI: _____ Office Fax Number: _____	