

An Outpatient Department of St. Mary's Hospital
2421 Malcom Bridge Rd Ste 820 Bogart, GA 30622-2325
Phone: 706-389-7802
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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

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

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Flushing Protocol <i>as needed for line care</i>	☐ Sodium Chloride 0.9% ☐ 5 mL ☐ 10 mL	Heparin 100 Units/mL ☐ 5 mL ☐ 10 mL
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: _____ Provider Signature: _____ Provider NPI: _____ Office Fax Number: _____ <i>Note: This order is valid for 12 months from date of physician signature.</i>		