

**STANDARD Abatacept PLAN OF TREATMENT**  
**Palmetto Infusion Services**

(Re)Certification Period From \_\_\_\_\_ to \_\_\_\_\_

**NOTE:** Patient is *ineligible* to receive Abatacept if receiving antibiotic for active infectious process due to the possibility of developing a superinfection related to its effect on the immune status, or has a suspected infectious process.

Patient's Name \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_ Allergies: \_\_\_\_\_

**DIAGNOSIS:**  714.0 or  714.2 Rheumatoid Arthritis

**Physician Office to Complete:**

1. Has your patient had failure, intolerance, or contraindication to conventional therapy?

Yes  No

2. If yes, please specify, treatment/medication tried and outcomes: \_\_\_\_\_

\_\_\_\_\_

Obtain weight each visit. **Infuse Abatacept over at least thirty minutes.**

Vital signs baseline, then every 15 minutes beginning with start of infusion and 30 minutes after completion for the first 3 treatments, after 3<sup>rd</sup> infusion Vital Signs pre and post infusion, then 30 mins after completion. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient for response to therapy.

**If adverse drug reaction, implement the Standing Adverse Reaction Protocol.**

Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn. Normal Saline Flush 3-10 ml before infusion, after primary drug has infused, Infuse Normal Saline 0.9% 20-50 ml to flush tubing/line followed by Heparin Lock 1 – 5 ml 100 unit/ml as needed per line type. Pump, tubings, and supplies needed to complete prescribed therapy.

**DOSE:** Usual dosage will based on the following guidelines provided by Bristol-Myers Squibb

**Dose of Abatacept**

Body Weight of Patient	Dose	Number of Vials (Each vial provides 250 mg of abatacept for administration)
< 60 kg	500 mg	2
60 to 100 kg	750 mg	3
> 100 kg	1 Gram	4

**FREQUENCY:**

\_\_\_\_\_ Orders to be completed at \_\_\_0, \_\_\_2, \_\_\_4 weeks, and \_\_\_every 4 weeks thereafter

\_\_\_\_\_ Orders every 4 weeks (maintenance).

\_\_\_\_\_ Special Orders:

**OTHER:**

Pharmacist to perform clinical drug monitoring.

Physician's Signature: \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_

(Dispense as written)

(Substitution permitted)

**PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION to**  
**TOLL FREE FAX (866) 872-8920**

**Patient should have a negative PPD within 6 months, or documented absence of active TB.**

Does the patient have a history of (circle each): TB SOB Cough Night Sweats Fever Weight Loss None

Has the patient had recent exposure to TB or been out of the country in the past month? \_\_\_Yes \_\_\_No

Does the patient have a family history of TB? \_\_\_Yes \_\_\_No

Has the patient had a PPD test? \_\_\_Yes \_\_\_No Date \_\_\_\_\_ Results \_\_\_\_\_

**(greater than or equal to 5 mm induration is + for this patient population)**

Chest X-Ray \_\_\_Yes \_\_\_No Results: \_\_\_\_\_ Previous Treatment for TB? \_\_\_Yes \_\_\_No