



MRN: \_\_\_\_\_

DOB: \_\_\_\_\_

Phone: 1-800-809-1265 Fax: 1-866-872-8920

**STANDARD Orencia® (abatacept) PLAN OF TREATMENT for Pediatric – (6 years of age or older)**

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

**NOTE:** Patient may be ineligible to receive abatacept if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new or worsening diagnosis of COPD or respiratory status, and/or surgery.

**1. Patient Name:** \_\_\_\_\_ Height (inches): \_\_\_\_\_ Weight (lbs): \_\_\_\_\_

**2. Allergies:** \_\_\_\_\_

**3. Diagnosis:** \* Please complete the 2<sup>nd</sup> and 3<sup>rd</sup> digits to complete the ICD-10 code for billing

- M08.0** \_\_\_\_\_ Unspecified Juvenile Rheumatoid Arthritis     **M08.2** \_\_\_\_\_ Juvenile Rheumatoid Arthritis with Systemic Onset
- M08.3** \_\_\_\_\_ Juvenile Rheumatoid Polyarthritis (seronegative)     **M08.4** \_\_\_\_\_ Pauciarticular Juvenile Rheumatoid Arthritis
- Other **ICD-10 Code:** \_\_\_\_\_ **Diagnosis description:** \_\_\_\_\_

**4. Pre-medications:**  None **OR** Administered 30 minutes prior to infusion as selected:

*\*Product information does not suggest premedication and will only be given as specified by referring MD.*

- a) Acetaminophen \_\_\_\_\_ mgs PO or  Liquid 160mg/5ml dose of \_\_\_\_\_ mls as specified by referring MD
- b) Diphenhydramine: \_\_\_\_\_ mgs PO or \_\_\_\_\_ mgs IV  Liquid 12.5mg/5ml dose of \_\_\_\_\_ mls as specified by referring MD
- c) Pre-medicate with other: \_\_\_\_\_

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**Orders:** Obtain weight each visit. **Vital signs at baseline, 15 minutes after start of infusion, at completion, and 30 minutes after completion for the first 3 treatments. Vital signs with subsequent infusions: at baseline and every 30 minutes until infusion completed, and then may discharge.** Instruct patient/caregiver on medications and signs/symptoms of adverse reaction. Assess patient for response to therapy. Utilize existing central line for administration or initiate a peripheral IV with each infusion as needed. Sodium Chloride 0.9% flush 3-10 ml before, after, and as needed during the infusion. Follow infusion with Pediatric Heparin 10 units/ml 1-5 ml or Heparin 100 units/ml 1 – 5 ml per line type or to peripheral IV as required for multiple day treatments. Pump, tubing, 0.22 micron filter, and supplies needed to include silicone-free syringe for reconstitution to complete prescribed therapy. Pharmacist to perform clinical drug monitoring. **If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES.**

**5. Dose:** Orencia® (abatacept) dosage per 100 ml Sodium Chloride 0.9% IV to infuse over at least 30 minutes.

**Orencia® (abatacept) dosage will be based on the following guidelines provided by Bristol-Myers Squibb**

Body Weight of Patient	Dose	Number of 250mg (abatacept) Vials
Less than 75 kg	10mg/kg	Weight based dose
75 to 100 kg	750 mg	3
More than 100 kg	1000 mg	4

**6. Frequency:** \_\_\_\_\_ Induction orders to be completed at 0 week, 2 week, and 4 weeks, and then every 4 weeks thereafter  
 \_\_\_\_\_ Orders every 4 weeks (maintenance).  
 \_\_\_\_\_ Special Orders: \_\_\_\_\_

Lab orders with infusions: \_\_\_\_\_

**7. Physician's Signature:** \_\_\_\_\_ / \_\_\_\_\_ Date: \_\_\_\_\_  
 No Stamp Signatures                      (Dispense as written)                      (Substitution permitted)

Printed Physician's Name with Credentials: \_\_\_\_\_

**8. Fax updated supporting clinical MD notes with each order renewal or change in orders**

*Infusion order forms available at [www.palmettoinfusion.com](http://www.palmettoinfusion.com)*



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Guidelines for Prescribing Orenzia® (abatacept) for Rheumatology for Pediatric – (6 years of age or older)
(Required documentation with all initial referrals)

Patient Name: \_\_\_\_\_

Referral Date: \_\_\_\_\_

Include signed and completed Plan of Treatment. (MD must complete sections 1-8)
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

Include patient demographic information and insurance information. (Copy of insurance cards if available)

Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or
contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.
Orenzia® is indicated for moderately to severely active polyarticular juvenile idiopathic arthritis in pediatric patients 6 years of
age and older. ORENCIA may be used as monotherapy or concomitantly with methotrexate.

If patient is switching biological therapies, then MD must specify wash-out period prior to starting Orenzia®
as specified of \_\_\_\_\_ weeks. Last known biological therapy: \_\_\_\_\_ and last date
received: \_\_\_\_\_. (Include copy of last Orenzia® infusion record if available and currently on therapy)

Other as requested: \_\_\_\_\_

Pre-Screening: (TB and Hepatitis screening results must be available prior to start of therapy and within last 12 months)

Required TB screening results: PPD or QuantiFERON Gold Test.
(\* If screening results are positive or indeterminate, then a negative CXR result is required.)

Required Hepatitis screening to include: Hepatitis B Surface Antigen results.

\*\* Warnings/Precautions: Patient should not have an active ongoing infection, signs or symptoms of malignancy, or invasive fungal
infection. COPD patients may develop more frequent respiratory adverse events. Orenzia® in patients with RA and COPD should be
undertaken with caution and such patients should be monitored for worsening of their respiratory status. Blood Glucose Monitoring:
Orenzia® contains maltose and can interfere with the readings of blood glucose monitors that use test strips with (GDH-PQQ), resulting
in falsely elevated blood glucose readings on the day of infusion. Hepatitis B Reactivation: Monitor HBV carriers during and several
months after therapy. If reactivation occurs, stop Orenzia® and begin anti-viral therapy. Evaluation of immunizations should be
completed prior to and live vaccines should not be given before or concurrently with Orenzia®. See full prescribing information.

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's
insurance company for eligibility. Our office will notify you if any further information is required. We will review financial
responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.