

STANDARD ORENCIA PLAN OF TREATMENT

(Re)Certification Period from _____ to _____

Note: Patient is *ineligible* to receive Orencia if receiving antibiotic for active infectious process (due to the possibility of developing a super-infection related to its effect on the immune status), or if he/she has a suspected infection.

PATIENT'S NAME _____ **HT:** _____ **WT:** _____ **Allergies:** _____

Diagnosis: 714.0 Rheumatoid Arthritis 714.2 Other Rheumatoid Arthritis

Please send documentation regarding severity or body surface area affected

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: _____

Order:

Obtain weight each visit. Vital signs baseline, then every 15 minutes beginning with start of infusion and 30 minutes after completion for the first 3 treatments; after 3rd infusion vital signs pre and post infusion. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. **If adverse drug reaction, implement the Standard Adverse Reaction Protocol.**

Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn.

Normal Saline Flush 5 ml before and after infusion 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 be based on the following guidelines provided by Bristol-Myers Squibb (MFG)

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

Infuse over at least 30 minutes

Frequency: Orders to be completed at 0 week 2 weeks & 4 weeks, **then:**

Orders every 4 weeks (maintenance)

Special Orders: _____

Other: Pharmacist to perform clinical drug monitoring.

(no stamped signatures please)

Physician's Signature: _____ Date: _____
(Dispense as written) (Substitution permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION TO 866-872-8920

Patient should have a negative PPD within 6 months, documented absence of active TB, as well as documented Hep B surface antigen.

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 Chest X-Ray: Yes No Results: _____

Has the patient had a PPD test? Yes No Date _____ Results _____ **Palmetto must have copy on file**

Any previous treatment for TB? Yes No

Has patient received **TNF therapy in past 6 months?** Yes No Therapy: _____ Last date Received: _____

Hep B surface antigen drawn: Yes No Please fax results with referral along with PPD results