Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265 DOB: _____

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)

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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