**MRN:**_____

DOB:_____

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

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 2nd and 3rd 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:** ***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: _____

***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: _____

**MRN:**_____

DOB:_____

Guidelines for Prescribing Orencia® (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**.

☐ 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.**

- Orencia® 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 Orencia® as specified of_____weeks. Last known biological therapy:_____and last date received:_____. (Include copy of last Orencia® infusion record if available and currently on therapy)

☐ Other as requested: _____

_____

**Pre-Screening:**

☐ **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. Orencia® 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:** Orencia® 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 Orencia® and begin anti-viral therapy. Evaluation of immunizations should be completed prior to and **live vaccines** should not be given before or concurrently with Orencia®. See full prescribing information.

Checklist for referrals to AccuRX Infusion Center:

Fax referral to 1-866-990-3192

- Patient demographics – address, phone number, SS#, etc.
- Insurance Information – copy of the card(s) if possible
- Plan of Treatment/Orders
- Most recent physician office notes to include tried and failed therapies – all insurance companies that require a pre-authorization require the note. This includes Medicare/Medicaid HMOs
- Any lab results or other diagnostic procedures to support the diagnosis

AccuRx Infusion Center 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.