Palmetto INFUSION®

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

Referral Status:			MRN:
☐ New referral	☐ Order change	☐ Order Renewal	
Patient preferred clinic:			

Orencia® (abatacept) Pediatric Standard Plan of Treatment

PATIENT DEMOGRAPHICS:

Date of Referral:		Patient's Phone:	
Patient Name:		Address:	
Date of Birth:		City, State, Zip:	
Height in inches:	Weight: LB or KG	Gender:	Allergies: ☐ See list ☐ NKDA

DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING)

☐	M08.0_____ - Unspecified Juvenile Rheumatoid Arthritis	☐	M08.2_____ - Juvenile Rheumatoid Arthritis with Systemic Onset
☐	M08.4_____ - Polyarticular Juvenile Rheumatoid Arthritis	☐	M08.3 - Juvenile Rheumatoid Polyarthritis (seronegative)
☐	_____- Other:_____		

REQUESTED DOCUMENTATION:

1	Insurance information
2	Most recent History & Physical
3	Full medication list
4	Tried and failed therapies
5	**REQUIRED:** TB screening for new start patients
6	HBV screening/labs as required by payor

PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

IF YES:
LAST INFUSION DATE:
NEXT INFUSION DATE:

IF ORDER CHANGE:

☐ **Continue current order until insurance approved**

MEDICATION ORDERS:

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.

PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED

IV	Diphenhydramine	☐	25mg	☐	50mg				
	Methylprednisolone	☐	40mg	☐	125mg	☐	Other:		
	Famotidine	☐	20mg	☐	40 mg				
	Other:	☐							
PO	Acetaminophen	☐	325mg	☐	500mg	☐	160mg/5ml	mls	
	Famotidine	☐	20mg	☐	40mg				
	Diphenhydramine	☐	25mg	☐	50mg	☐	12.5mg/5ml:	mls	
	Loratadine	☐	10mg						
	Other:	☐							

DRUG PRODUCT:

☑ Orencia® (abatacept) dosage per 100 ml NS given IV to infuse over at least 30 minutes.

DOSE:

☐ Dose based on guidelines below from the FDA package labeling

Patient Weight	Dose	250mg Vials
< 75kg	10mg/kg	undefined
75kg to 100kg	750mg	3
More than 100kg	1000mg	4

☐ Flat dose: _____mg

FREQUENCY:

☐ Induction: To be given at 0 week, 2 week, and 4 weeks, and then every 4 weeks thereafter

☐ Maintenance: Every 4 weeks

☐ Other: _____

SPECIAL/LAB ORDERS:

☐ _____

_____

Prescriber confirms that the patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment. Prescriber to monitor patient for symptoms of HBV and TB infection and reactivation as clinically appropriate.

☑ Refills x 12 months unless noted otherwise here:

LINE USE/CARE ORDERS:

☑ Start PIV/Access CVC

☑ Flush device per facility standard flushing procedure

ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

PRESCRIBER INFORMATION:

PROVIDER NAME:	PHONE:
ADDRESS:	FAX:
CITY, STATE, ZIP:	NPI:

PRESCRIBER SIGNATURE: (No stamp signatures)		DATE:
Dispense as written/Brand medically necessary	Substitution permitted	