| 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 | TB screening results |
| 6 | HBV screening/labs as required by payor |

IF NO: PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:

## PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

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 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 | |

Palmetto
INFUSION

# Checklist for referrals to Palmetto Infusion:

## Fax referral to 1.866.872.8920

- ☐ **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**

Palmetto Infusion 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. Palmetto Infusion Call Center 800.809.1265. Thank you for the referral.

www.PalmettoInfusion.com

02/10/2023