

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Orencia® (abatacept) 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	IF NO:	IF YES:
2	Most recent History & Physical	PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	LAST INFUSION DATE:
3	Full medication list		NEXT INFUSION DATE:
4	Tried and failed therapies		IF ORDER CHANGE: <div style="border: 1px solid black; padding: 5px; text-align: center;"> Continue current order until insurance approved </div>
5	REQUIRED: TB screening for new start patients		
6	HBV screening/labs are required by payor		

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		PO	Acetaminophen	325mg	500mg	160mg/5ml	mls
	Methylprednisolone	40mg	125mg	Other:		Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg	12.5mg/5ml:	mls
	Other:					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
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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