

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

Orencia® (abatacept) Plan of Treatment for Rheumatology

Rev 4.29.25

PATIENT DEMOGRAPHICS:

Patient Name: _____

Patient's Phone: _____ 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)

M05. _____ - Rheumatoid Arthritis with Rheumatoid factor

M06. _____ - Rheumatoid Arthritis without Rheumatoid factor

_____ - 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:	IF YES:
PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY:	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	Other:	PO	Acetaminophen	325mg	500mg	650mg	1000mg
	Methylprednisolone	40mg	125mg			Famotidine	20mg	40mg		
	Famotidine	20mg	40 mg			Diphenhydramine	25mg	50mg		
	Other:					Fexofenadine	60mg	180mg		
						Cetirizine	10mg			
				Loratadine	10mg					
				Other:						

MEDICATION:

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

DOSE:

Dosage based on the following guidelines from the FDA package labeling.

Patient Weight	Dose	250 mg vials
<60 kg	500 mg	2
60 to 100kg	750 mg	3
>100 kg	1000 mg	4

Flat Dose: _____mg

FREQUENCY:

Induction: To be given at 0 week, 2 week, and 4 weeks

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:

NURSING 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.

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