

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

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 2<sup>ND</sup> AND 3<sup>RD</sup> 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		<b>IF ORDER CHANGE:</b>  <b>Continue current order until insurance approved</b>
5	<b>REQUIRED:</b> 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	Other:	PO	Acetaminophen	325mg	500mg	160mg/5ml	mls
	Methylprednisolone	40mg	125mg			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.

## 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
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