

Orencia (Abatacept) Infusion Order

PatientName: Diagnosis (please provide ICD10 code): _____ DOB: _____ Male Female

Other: _____
 NKDA Allergies: _____
 New Therapy Order Continuation of Therapy Date of last dose: _____

Ordering Provider Name: _____
 Provider NPI: _____ Phone: _____ Fax: _____
 Practice Address: _____ City: _____ State: _____ Zip Code: _____

Pre-Medication

- Acetaminophen _____mg by PO
- Cetirizine _____mg by PO
- Diphenhydramine _____mg by PO/ IVP
- Solu-Medrol _____mg by PO/ IVP
- Solu-Cortef _____mg by PO/ IVP
- Other: _____

Required Documentation:

- Patient Demographics
- Patient Insurance (med and pharm card copies, front and back)
- Progress Notes/Labs supporting diagnosis
- Hepatitis B
- CBC, CMP,ESR,CRP lab results
- Quantiferon
- List of tried&failed therapies
- Other: _____

Orencia is a weight-based medication:

Patient Height (cm): _____
 Patient Weight (kg): _____

Orencia Medication Order: Rheumatoid Arthritis

- Induction Dosing on weeks 0, 2, and 4 followed by maintenance
 - Intravenous Dosing (Please choose one)
 - If <60kg, 500mg
 - If 60kg to ≤100kg, 750mg
 - If >100kg, 1000mg
 - Other: _____
 - Maintenance Frequency (Please choose one)
 - Every 4 weeks
 - Other: _____
- Maintenance dose every 4 weeks only
 - Intravenous Dosing (Please choose one)
 - If <60kg,500mg
 - If 60kg to≤100kg, 750mg
 - If >100kg,1000mg
 - Other: _____

S/IA

- Induction Dosing on weeks 0, 2, and 4 followed by maintenance
 - Intravenous Dosing (Please choose one)
 - If <75kg, 10mg/kg (Max dose of 1000mg)
 - If 75kg to ≤100kg, 750mg
 - If >100kg, 1000mg
 - Other: _____
 - Maintenance Frequency (Please choose one)
 - Every 4 weeks
 - Other: _____
- Maintenance dosing every 4 weeks
 - Intravenous Dosing (Please choose one)
 - If <75kg,10mg/kg (Max dose of 1000mg)
 - If 75kg to≤100kg, 750mg
 - If >100kg,1000mg
 - Other: _____

<p>Additional Instructions/Notes:</p>	<p>Patient IV Access</p> <ul style="list-style-type: none"> <input type="checkbox"/> PIV <input type="checkbox"/> Use patient's SL/DL PICC, flush per protocol <input type="checkbox"/> Access/deaccess patient's Port, flush per protocol *Imaging results of proper placement required for PICC/Port
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Ordering Provider:

Signature: _____ Date: _____
 Provider: _____ Phone: _____ Fax: _____
 Best Contact Person in Office: _____ Phone: _____

Locations:

- Skokie, IL: 4711 Golf Rd, Ste 900. P: 847-324-6800. F: 224-251-7141
- Libertyville, IL: 1900 Hollister Dr, Ste 210. P: 847-324-6800. F: 224-251-7141
- Houston, TX: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400