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Orencia (Abatacept) Infusion Order

Patient Name: DOB: □Male □Female

Diagnosis (please provide ICD10 code):

□ 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:

Orencia is a weight-based medication:

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

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 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:_____

SJIA

□ 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:_____

Additional Instructions/Notes:

Patient IV Access

□ PIV
□ Use patient's SL/DL PICC, flush per protocol
□ Access/deaccess patient's Port, flush per protocol
*Imaging results of proper placement required for PICC/Port

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
□ *Orland Park, IL*: 16612 107th Ct, Ste B. P: 847-324-6800. F: 224-251-7141
□ *Houston, TX*: 8303 SW Freeway, Ste 111. P: 346-738-9600. F: 346-613-8400