Fax Form to: 330-294-2082

INDY INFUSION

Abatacept (Orencia)

Provider Order Form *rev. 10/12/2022*

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight (lbs/kg): Height:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ TB status & date (list results here & attach clinicals)

☑ Provide nursing care per Nursing Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☐ **Abatacept** (Orencia) in 100ml 0.9% sodium chloride, intravenous infusion over 30 minutes (use in line filter 0.2 to 1.2 micron)
- Dose: ☐ 500mg / ☐ 750mg / ☐ 1000mg / ☐ _____mg
- Frequency: ☐ induction: week 0, 2, and 4, then every 4 weeks / ☐ maintenance: every 4 weeks / ☐ other: _____
- Route: ☑ intravenous
- Infuse over 30 minutes
- Remove equal volume from bag prior to adding medication

☑ Flush with 0.9% sodium chloride at infusion completion

☐ **Abatacept** (Orencia) injection
- Dose: ☐ 50mg/ ☐ 87.5mg/ ☐ 125mg
- Frequency: ☐ weekly / ☐ other: _____
- Route: ☑ subcutaneous

☐ Patient is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Screen for latent TB infection prior to initiating therapy. Patients testing positive should be treated prior to initiating ORENCIA.

Provider Name (Print) **Provider Signature** **Date**

Please include the following information when submitting a referral for Orencia:
*Patient's current weight and height
*Clinicals to support one or more of the following:
*Patient has rheumatoid arthritis (RA)
*Patient has juvenile idiopathic arthritis (JIA)
*Patient has psoriatic arthritis