ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Gig Harbor Infusion Services - Fax: 253-530-8069
❑ Allenmore Ambulatory Infusion Services - Fax: 253-864-4052
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ Auburn Infusion Services - Fax: 253-876-8282
❑ North Spokane Infusion Center - Fax: 509-232-2531

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Abatacept (Orencia)

Patient Name:____ Requested Date of Service: ________ /________ /________

Date of Birth: ______ /______ /_______ Patient Phone Number: (______) ________ - ____________________ ❑ May leave message

Diagnosis:
- ❑ Rheumatoid Arthritis
- ❑ Other__________________________

ICD -10 Code:
- ❑_____________________________________
- ❑_____________________________________

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available

❑ **Reason patient not able to self-administer medication** ____

____

Baseline labs required:
- Latent TB testing Date: ______/______/______ Results: ______________________
- HBV screening Date: ______/______/______ Results: ______________________

Maintenance labs required:
- Annual Latent TB testing

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P: Peripheral IV Device Site Selection, Insertion, Maintenance, and Discontinuation; and Maintenance of Central Venous Catheters-Flushing, Dressing Changes and Removal.

Patient weight = _________lb/kg (required)

Treatment Regimen:
Abatacept (Orencia): Administered in 100 mL NS with 0.22 micron filter and infused over 30 minutes
- ❑ Patient weight <60 kg; Dose = 500 mg
- ❑ Patient weight 60-100 kg; Dose = 750 mg
- ❑ Patient weight >100 kg; Dose = 1000 mg
- ❑ Initiation Dose: every 2 weeks x 3 doses then every 4 weeks x 12 months
- ❑ Continue maintenance dose of _________ every 4 weeks x 12 months

☑ **Vital Signs:** Check vital signs prior to and at completion of infusion.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If hypersensitivity develops (fever, chills, hypotension, rigors, itching, rash, etc.):
- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for futher orders

Code Status: Please note, patients' will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

______________________	______________________	__________	__________
Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Orders expire in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
ABATACEPT (Orencia)

78-2777-6MR (Rev. 1/22)