

General

Patient Name _____ DOB _____ Height _____ Weight _____ Phone # _____

 Order Start Date _____ Order Expiration Date (*max one year*) _____

Allergies: _____

Guidelines for Ordering:

1. Send **FACE SHEET** and **H&P** or most recent chart note.
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment. Please send results with order.
3. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
4. Abatacept has been associated with an increased incidence of adverse respiratory side effects (COPD exacerbation, cough, rhonchi, dyspnea) in patients with COPD. Providers should counsel patients with COPD on the risk of disease exacerbation and consider avoidance of therapy when appropriate. At a minimum, frequent monitoring is recommended.
5. The patient should not have an active infection at the time of therapy initiation.

PRE-SCREENING (Results must be available prior to initiation of therapy):

- Hepatitis B surface antigen and core antibody test results scanned with orders
- Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- Chest X-Ray result scanned with orders if TB test result is indeterminate

DIAGNOSIS CODE: *MUST include ICD10 code**

- L40.5 Psoriatic Arthritis M06.9 Rheumatoid Arthritis
- Other: _____

Labs:

- Complete Metabolic Panel, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- Labs already drawn. Date: _____

Nursing Orders

- TREATMENT PARAMETER: Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed
- TREATMENT PARAMETER: Hold infusion and contact provider if patient has signs or symptoms of infection.

IV ACCESS: Place peripheral IV Access Implanted Port

If nurse to access implanted port please complete Port Access Order Set as well

- Vital Signs: Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion, then every 15 minutes x 30 minutes, then every 30 minutes until infusion is completed. Consider observing patient for 30-minutes following infusion.

Patient Name:
 DOB:

Pre-Medications (*administer 30 minutes prior to infusion*):

- Acetaminophen (Tylenol) 650mg PO x1 dose Diphenhydramine (Benadryl) 50mg PO x1 dose

Medication Orders

Initial Doses:

Abatacept (Orencia) in sodium chloride 0.9% (Total volume 100 mL) intravenous, ONCE over 30 minutes. Use a sterile, non-pyrogenic, low protein-binding filter (0.2-1.2 microns). Administer within 24 hours of preparation.

- 500 mg – Patient weight less than 60 kg
 750 mg – Patient weight 60-100 kg
 1000 mg – Patient weight greater than 100 kg

Interval (*Must check one*):

- Once
 Three doses at 0, 2, and 4 weeks
 Other: _____

Maintenance Dose

Abatacept (Orencia) in sodium chloride 0.9% (Total volume 100 mL) intravenous, ONCE over 30 minutes. Use a sterile, non-pyrogenic, low protein-binding filter (0.2-1.2 microns). Administer within 24 hours of preparation.

- 500 mg – Patient weight less than 60 kg
 750 mg – Patient weight 60-100 kg
 1000 mg – Patient weight greater than 100 kg

Interval:

- Every _____ weeks for _____ doses (Beginning at week 8 = every 4 weeks, at least 28 days apart)

MANAGEMENT OF SIDE EFFECTS

In the event of an adverse reaction, which can be characterized by unexpected physiological responses such as a notable decrease in blood pressure, gastrointestinal distress (nausea and diarrhea), headache or other concerning symptoms: Hold infusion x 30 mins, if symptoms improve resume infusion at half previous rate, if symptoms persist consider administering 500ml IV sodium chloride 0.9% bolus and call provider. If after hours, call the hospitalist.

IF ANAPHYLACTIC REACTION OCCURS

Stop infusion immediately, notify provider and/or Hospitalist on duty if afterhours, administer oxygen prn, administer Benadryl 50 mg IV or IM once STAT, administer Epinephrine (1:1000) 0.5mg IM once STAT, possible admission to emergency department for further evaluation/treatment.

Patient Name:
DOB:



Ordering Facility/Provider Information

By signing below, I affirm the following:

I am responsible for the care of the patient identified on this form.

I hold an active, unrestricted license to practice medicine in _____ (*specify state*)

My physician license number is # _____ and I am acting within my scope of practice and authorized by law to order infusion of the medication described above for the patient identified on this form.

Provider Signature: _____	Date _____
Printed name: _____	Phone: _____ Fax: _____

KVH Provider Co-signature: <i>*Required for all external orders</i>	
Provider Signature: _____	Date _____
Printed name: _____	

<i>Patient Name:</i>
<i>DOB:</i>