Ascension St. Vincent's
Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Abatacept (Orencia) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information

Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐	

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐ Rheumatoid Arthritis ☐ Psoriatic Arthritis ☐ Other: _____	☐ M06.00, M06.9, M05.9, M05.89 ☐ L40.53, L40.50 ☐ Other: _____	☑ J0129	☑ CPT Code: _____

Labs (prior to scheduling infusion)	Other Labs:
☑ TB test ☑ Hepatitis B Surface Antigen Level ☑ Hepatitis B Core Total Antibody Level Test	☐ _____ ☐ _____ ☐ _____

Nursing Orders	Pre-Medications (not required)	
☑ Discharge patient when stable and meets protocol criteria	☐ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
Emergency/Anaphylaxis Order	☐ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☑ Follow standard orders for management of allergies and anaphylaxis reactions	☐ Dexamethasone 20 mg IV, once	☐ Other: _____
	☐ Ondansetron 4 mg IV, once	☐ Other: _____

Medication Orders

	Medication	Route	Dose	Frequency	Select Treatment Type
☑	Abatacept	IVPB	☐ 500 mg over 30 mins (< 60 kg) ☐ 750 mg over 30 mins (60 - 100 kg) ☐ 1,000 mg over 30 mins (> 100 kg) Pharmacy to adjust dose based on patient's current weight	Once	☐ Initiation: Every 2 weeks for 2 doses ☐ Maintenance: Every 4 weeks for ____ dose(s) ☐ On weeks 0, 2, 4 then every 4 weeks for ____ doses(s) ☐ Other: _____

Administration Instructions: Do not administer abatacept concomitantly in the same IV line as other agents.
*Pharmacy may adjust dose +/- 10% of calculated dose per Pharmacy and Therapeutics Committee approved protocol.

Infusion Center Staff Please fax infusion records or discharge summary to:	**Fax Number** _____

Provider Signature		**Date**	
Provider Printed Name			