Mankato Clinic
Together we thrive.

ADULT AMBULATORY INFUSION ORDER

Abatacept (ORENCIA)

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Date: _______/_______/________

***Please fax a copy of the following patient information:** ☐ Demographics ☐ Insurance Information ☐ Current Lab Results ☐ H & P Relevant to Diagnosis ☐ Last infusion note ☐ Current Medications

PATIENT INFORMATION

Allergies: ___________________________________

Weight: _____________ lbs/kg Height: ________

Diagnosis: _________________________________

ICD-10: ___________________________________

PROVIDER INFORMATION

Printed Provider's Name: _________________________

Signature: ______________________________________

NPI: ____________________ Date: ___/_____/______

Phone: (____)_____-_______ Fax: (____)____-_______

Office Address: __________________________________

Contact Person: _________________________________

TB Result: ____________________________ Test Date: _____/______/_________ ☐ Copy Attached

Hep B Result: ______________________ Test Date: _____/______/_________ ☐ Copy Attached

PRE-MEDICATIONS:

Diphenhydramine: ☐ PO ☐ IV ☐ 25 mg ☐ 50mg

Acetaminophen: ☐ PO ☐ 650 mg ☐ 1000 mg

Other: ☐ ____

☐ No Pre-Medications

WAIT TIME AFTER PRE MEDICATIONS:

☐ 20 minutes ☐ 30 minutes ☐ Other: ______________ ☐ No wait time

LABS:

☐ CBC w/diff ☐ EVERY infusion ☐ every OTHER infusion ☐ other: ______________________

☐ CMP ☐ EVERY infusion ☐ every OTHER infusion ☐ other: ______________________

☐ CRP ☐ EVERY infusion ☐ every OTHER infusion ☐ other: ______________________

☐ Other: __________ ☐ EVERY infusion ☐ every OTHER infusion ☐ other: ______________________

☐ No labs needed

ORENCIA (abatacept) IV DOSAGE

Dose: ☐ **500 mg (< 60 kg)** ☐ **750 mg (60-100 kg)** ☐ **1000 mg (>100 kg)** ☐ **Other:** ___________

Frequency: ☐ **Initial Dose** ☐ **2 and 4 weeks** ☐ **q 4 weeks**

Duration: ________________________________