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| ADULT AMBULATORY INFUSION ORDER **Abatacept (ORENCIA)** |   **NAME:** **BIRTHDATE:** *Affix Patient Identification Label Here* |
| **ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (**  **) TO BE ACTIVE.**  |

**Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

\***Please fax a copy of the** □Demographics □ Insurance Information □ Current Lab Results

**following patient information**: □ H & P Relevant to Diagnosis □ Last infusion note □ Current Medications

Provider Information

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Information

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ lbs/kg Height: \_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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

MC2692 (05/22)

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**