Dear Provider,

Specialty therapies can be complex, and complete information is essential to help ensure timely access to care.

The following prescriber order form is designed to capture the necessary clinical and patient information the dispensing pharmacy requires to begin the applicable prescribed therapy.

If your patient has elected to use Option Care Health, please fax completed form and required clinical documentation to **713-983-4647**.

Sincerely,
Option Care Health

ABATACEPT (ORENCIA®) PRESCRIBER ORDER FORM

Patient Name:			**Date of Birth:**	**Gender:**
Address:				
Phone:	**Height:**	☐ inches ☐ cm	**Weight:**	☐ lbs ☐ kg

Clinical Information

Primary Diagnosis Description:			**ICD-10 Code:**
Allergies: ☐ NKDA OR (List):			
Is this the first dose?	☐ Yes – date of first dose: ☐ No – date of last dose:	**Hepatitis B Status:**	Titer Date: ☐ Positive ☐ Negative

TB Status:

☐ PPD (negative) – date:
☐ Last chest x-ray – date:
☐ Past positive TB infection, course taken:
☐ QuantiFERON or T Spot Assay result and date:
☐ Active TB
☐ Unknown

Abatacept (Orencia®) Prescription

Abatacept (Orencia®) INTRAVENOUS refill as directed x 1 year

Initial Dose:
- ☐ Infuse 500 mg IV over 30 minutes on Weeks 0, 2, and 4 (patient weight < 60 kg)
- ☐ Infuse 750 mg IV over 30 minutes on Weeks 0, 2, and 4 (patient weight 60 to 100 kg)
- ☐ Infuse 1000 mg IV over 30 minutes on Weeks 0, 2, and 4 (patient weight > 100 kg)
- ☐ Other: _____

Maintenance Dose:
- ☐ Infuse 500 mg IV over 30 minutes every 4 weeks (patient weight < 60 kg)
- ☐ Infuse 750 mg IV over 30 minutes every 4 weeks (patient weight 60 to 100 kg)
- ☐ Infuse 1000 mg IV over 30 minutes every 4 weeks (patient weight > 100 kg)
- ☐ Other:

Abatacept (Orencia®) SUBCUTANEOUS refill as directed x 1 year

- ☐ Optional loading dose of _____mg IV administered once
- ☐ 125mg subcutaneously once weekly (within a day of IV infusion if infusion given)
- ☐ Other: _____

Ancillary Orders

Anaphylaxis Kit

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Skilled Nursing to establish peripheral IV access as needed to manage anaphylaxis

Medication Orders

- ☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for headache or mild discomfort. Patient may decline.
- ☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may decline.
- ☐ Methylprednisolone sodium succinate 40 mg IV push 20 minutes prior to infusion.
- ☐ Other: _____

IV Flush Orders

- Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr if accessed or weekly to monthly if not accessed.

Lab Orders

- ☐ No labs ordered at this time.
- ☐ Other: _____

Skilled nurse to assess and administer and/or teach self-administration, where appropriate, via access device as indicated above. Nurse will provide ongoing support as needed. Refill above ancillary orders as directed x 1 year.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:		**Phone:**	**Fax:**
Address:		**NPI:**	
City, State:	**Zip:**	**Office Contact:**	

