



option care health®

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:	<input type="checkbox"/> inches <input type="checkbox"/> cm
	Weight:	<input type="checkbox"/> lbs <input type="checkbox"/> kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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Allergies: NKDA OR (List):

Is this the first dose?	<input type="checkbox"/> Yes – date of first dose: <input type="checkbox"/> No – date of last dose:	Hepatitis B Status:	Titer Date:
		<input type="checkbox"/> Positive <input type="checkbox"/> Negative	

TB Status:	<input type="checkbox"/> PPD (negative) – date: <input type="checkbox"/> Last chest x-ray – date: <input type="checkbox"/> Past positive TB infection, course taken: <input type="checkbox"/> QuantiFERON or T Spot Assay result and date:	<input type="checkbox"/> Active TB <input type="checkbox"/> Unknown
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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:

CONFIDENTIAL HEALTH INFORMATION: Healthcare information is personal information related to a person's healthcare. It is being faxed to you after appropriate authorization or under circumstances that do not require authorization. You are obligated to maintain it in a safe, secure, and confidential manner. Re-disclosure of this information is prohibited unless permitted by law or appropriate customer/patient authorization is obtained. Unauthorized re-disclosure or failure to maintain confidentiality could subject you to penalties described in federal and state laws. **IMPORTANT WARNING:** This message is intended for the use of the person or entity to whom it is addressed and may contain information that is privileged and confidential, the disclosure of which is governed by applicable law. If the reader of this message is not the intended recipient, or the employee or agent responsible for delivering it to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this information is STRICTLY PROHIBITED. If you have received this message in error, please notify us immediately. Brand names are the property of their respective owners.