


ABATACEPT (ORENCIA®) PRESCRIBER ORDER FORM

Fax completed form, insurance information, and clinical documentation to:

 option care health	Patient Name:		Date of Birth:	
	Address:			
	Phone:	Height:	<input type="checkbox"/> inches <input type="checkbox"/> cm	Weight:

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:
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Is this the first dose?	<input type="checkbox"/> Yes – date of first dose:	Hepatitis B Status:	Titer Date:
	<input type="checkbox"/> No – date of next dose due:		<input type="checkbox"/> Positive <input type="checkbox"/> Negative

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

Abatacept (Orencia®) Prescription

Abatacept (Orencia®) 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: _____

Ancillary Orders

Anaphylaxis Kit
 → Required per Option Care Health policy – please complete Anaphylaxis Physician Order (FR-PC-036) provided.

Medication Orders

Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever 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 40 mg IV push 20 minutes prior to infusion.

Other: _____

IV Flush Orders

Peripheral: NS 2 to 3 mL pre-/post-use.

Implanted Port: NS 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.

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

Prescriber Signature:	Date:
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Prescriber Information

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

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