Abatacept (Orencia)

Provider Order Form rev. 3/25/2022

IVX HEALTH

PATIENT INFORMATION

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ TB status and date (results) _____

☑ Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____

☐ CMP ☐ at each dose ☐ every _____

☐ CRP ☐ at each dose ☐ every _____

☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO

☐ cetirizine (Zyrtec) 10mg PO

☐ loratadine (Claritin) 10mg PO

☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV

☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV

☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV

☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☐ **Abatacept** (Orencia) in 100ml 0.9% sodium chloride, intravenous infusion over 30 minutes (use in line filter 0.2 to 1.2 micron)
- Dose: ☐ 500mg / ☐ 750mg / ☐ 1000mg / ☐ _____mg
- Frequency: ☐ induction: week 0, 2, and 4, then every 4 weeks / ☐ maintenance: every 4 weeks / ☐ other: _____
- Route: ☑ intravenous
- Infuse over 30 minutes
- Remove equal volume from bag prior to adding medication

☑ Flush with 0.9% sodium chloride at infusion completion

☐ **abatacept** (Orencia) injection
- Dose: ☐ 50mg/ ☐ 87.5mg/ ☐ 125mg
- Frequency: ☐ weekly / ☐ other: _____
- Route: ☑ subcutaneous

☐ Patient is required to stay for 30-minute observation period

☐ Patient is NOT required to stay for observation time

☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____ (if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Screen for latent TB infection prior to initiating therapy. Patients testing positive should be treated prior to initiating ORENCIA.

Provider Name (Print) **Provider Signature** **Date**

FAX NUMBERS

	☐ CHICAGO: 312-253-7244	☐ INDIANAPOLIS: 844-983-2028	☐ PHILADELPHIA: 844-820-9641	☐ WEST TN/AR: 888-615-1445
	☐ COLUMBUS: 844-627-2675	☐ JACKSONVILLE: 904-212-2338	☐ RALEIGH: 919-287-2551	☐ MIDDLE TN: 888-615-1445
☐ BAY AREA: 844-889-0275	☐ DAYTONA: 386-259-6096	☐ KANSAS CITY: 844-900-1292	☐ SARASOTA: 941-870-6550	☐ EAST TN: 615-425-7427
☐ CHARLOTTE: 336-663-0143	☐ HARRISBURG: 844-859-4235	☐ ORLANDO: 844-946-0867	☐ SOUTHWEST FL: 813-283-9144	
☐ CINCINNATI: 844-946-0868	☐ HARTFORD: 860-955-1532	☐ PALM BEACH: 561-768-9044	☐ TAMPA: 844-946-0849	