

ORENCIA (ABATACEPT) IV INFUSION ORDER FORM

Full Name: Date of Birth:

Phone Number: Email Address:

Address:

Weight: lb/kg Allergies: ☐ NKDA ☐

Treatment Status: ☐ New ☐ Continued **Last Treatment Date:**

DIAGNOSIS (ICD-10 SELECTION)

- ☐ M05.79 – Rheumatoid arthritis with rheumatoid factor
- ☐ M06.9 – Rheumatoid arthritis, unspecified
- ☐ L40.50 – Arthropathic psoriasis
- ☐ Other: ☐ ICD-10 CODE:

INFUSION ORDER

Induction Phase:

- ☐ 500 mg IV at Weeks 0, 2, and 4
- ☐ 750 mg IV at Weeks 0, 2, and 4
- ☐ 1000 mg IV at Weeks 0, 2, and 4

Maintenance Phase:

- ☐ Same dose IV every 4 weeks
- ☐ Infuse over 30 minutes using 0.2–1.2 micron in-line filter
- ☐ Refills: ☐ None ☐ Monthly ☐ Other:

LINE USE & ACCESS

- ☐ Start PIV ☐ Access CVC ☐ Use PICC Line ☒ Flush per standard injection protocol

ADVERSE REACTION & ANAPHYLAXIS ORDERS

- ☒ Kaison Infusion Center Protocol (www.kaisoninfusion.com)
- ☐ Other - please fax preferred reaction orders to (405) 237-6305

PREMEDICATION (OPTIONAL)

- | | | | | |
|--|---------------------------------|---------------------------------|----------------------------------|-----------------------------|
| ☐ Acetaminophen: 500 mg | ☐ 500 mg | ☐ 650 mg | ☐ 1000 mg | ☐ PO |
| ☐ Diphenhydramine: | ☐ 25 mg | ☐ 50 mg | ☐ PO | ☐ IV |
| ☐ Methylprednisolone: | ☐ 40 mg | ☐ 125 mg | ☐ IV | |
| ☐ Cetirizine: | ☐ 10 mg | ☐ PO | | |
| ☐ Other: <input type="text"/> | Dose: <input type="text"/> | Route: <input type="text"/> | | |

LABORATORY MONITORING

- ☐ CBC ☐ CMP ☐ CRP ☐ CSR ☐ TB Screening ☐ Hepatitis B Panel ☐ Other:
- Frequency:** ☐ Prior to first dose ☐ Monthly ☐ Other:
- ☐ Physician office will order labs only

CLINICAL DOCUMENTATION CHECKLIST

- ☐ Recent progress notes ☐ Last H&P ☐ Lab results ☐ Medication list
- ☐ Documentation of prior DMARD or biologic therapy

ORDERING PROVIDER & DEMOGRAPHICS

Name: NPI: LICENSE #:

Contact: Phone: Fax:

Email: Signature: Date: