



Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO9031



ADULT AMBULATORY INFUSION ORDER
Abatacept (ORENCIA) Infusion

Page 1 of 3

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE

Weight: _____ kg Height: _____ cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ Patient to follow up with provider on date: _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note.**
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.
3. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
4. COPD is the most frequent side effect of abatacept therapy. Providers should, inform patients with COPD of the risk for exacerbation and consider excluding them from therapy. At a minimum, frequent monitoring is recommended.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- Hepatitis B surface antigen and core antibody total test results scanned with orders.
- Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:

- Complete Metabolic Panel, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – Circle One
- Labs already drawn. Date: _____

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, dec clotting (alteplase), and/or dressing changes.
4. VITAL SIGNS – Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion



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PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)

Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- acetaminophen (TYLENOL) tablet, 650 mg, oral, ONCE, every visit
- diphenhydrAMINE (BENADRYL) capsule, 50 mg, oral, ONCE, every visit.
Give either loratadine or diphenhydrAMINE, not both.
- loratadine (CLARITIN) tablet, 10 mg, oral, ONCE AS NEEDED if diphenhydrAMINE is not given, every visit. **Give either loratadine or diphenhydrAMINE, not both.**

MEDICATIONS:

Initial Doses:

Abatacept (ORENCIA) in sodium chloride 0.9% (Total volume 100 mL) intravenous, ONCE over 30 minutes. Use a sterile, non-pyrogenic, low protein-binding filter (0.2-1.2 microns). Administer within 24 hours of preparation.

- 500 mg – Patient weight less than 60 kg
- 750 mg – Patient weight 60-100 kg
- 1000 mg – Patient weight greater than 100 kg

Interval: (must check one)

- Once
- Three doses at 0, 2, and 4 weeks; dates: Week 0 _____, Week 2 _____, Week 4 _____

Maintenance Dose:

Abatacept (ORENCIA) in sodium chloride 0.9% (Total volume 100 mL) intravenous, ONCE over 30 minutes. Use a sterile, non-pyrogenic, low protein-binding filter (0.2-1.2 microns). Administer within 24 hours of preparation.

- 500 mg – Patient weight less than 60 kg
- 750 mg – Patient weight 60-100 kg
- 1000 mg – Patient weight greater than 100 kg

Interval:

- Every _____ weeks for _____ doses (Beginning at week 8 = every 4 weeks, at least 28 days apart)

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction



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By signing below, I represent the following:

I am responsible for the care of the patient (*who is identified at the top of this form*);

I hold an active, unrestricted license to practice medicine in: Oregon _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (**MUST BE COMPLETED TO BE A VALID PRESCRIPTION**); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____	Date/Time: _____
Printed Name: _____	Phone: _____ Fax: _____

Please check the appropriate box for the patient's preferred clinic location:

Hillsboro Medical Center
 Infusion Services
 364 SE 8th Ave, Medical Plaza Suite 108B
 Hillsboro, OR 97123
 Phone number: (503) 681-4124
 Fax number: (503) 681-4120

Adventist Health Portland
 Infusion Services
 10123 SE Market St
 Portland, OR 97216
 Phone number: (503) 261-6631
 Fax number: (503) 261-6756

Mid-Columbia Medical Center
 Celilo Cancer Center
 1800 E 19th St
 The Dalles, OR 97058
 Phone number: (541) 296-7585
 Fax number: (541) 296-7610