Oregon Medical Group Infusion Center

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Abatacept (Orencia) Orders

Name: ______________________________________ DOB: _____________________________

Diagnosis/Indication: ___________________________ ICD-10 Code: ________________________

Weight: ___________________

1. Vital signs: Initial, PRN
2. Peripheral IV site with saline lock, may use existing PICC line or port-a-cath if available.
3. Infuse intravenously Orencia, diluted in Sodium Chloride 0.9% 100ml, over 30 minutes.
   ☐ 500 mg (wt < 60 kg) ☐ 750 mg (wt 60-100 kg) ☐ 1 gram (wt > 100 kg)
4. Frequency of Orencia administration (please check one):
   ☐ Day 1, 2 weeks after day 1, 4 weeks after day 1 then every 4 weeks for _________ months (No longer than 12 months)
   ☐ Every 4 weeks for ________ months (No longer than 12 months)
   ☐ Other: ____
5. Pre-medications to be given 30 minutes prior to infusion (optional)
   ☐ OMG Infusion Center Pre-Medication Protocol
   <u>OR</u>
   ☐ Administer the following routine pre-medications prior to each infusion
      ☐ Acetaminophen (Tylenol) 650 mg PO
      ☐ Antihistamine (Select one)
         ☐ Diphenhydramine (Benadryl) 25 mg PO
         ☐ Diphenhydramine (Benadryl) 25 mg IV infusion over < 10 mins
         ☐ Loratadine (Claritin) 10 mg PO
      ☐ Methylprednisolone (Solu-Medrol) 40 mg IV infusion over < 10 min, not to exceed 50 mg/min
      ☐ Methylprednisolone (Solu-Medrol) 100mg IV infusion over < 10 min, not to exceed 50mg/min
      ☐ Ondansetron 4 mg IV **<u>OR</u>** ☐ Ondansetron 8 mg IV
   ☐ Other: ____
6. For infusion reaction (**<u>Must select one to be considered a complete order</u>**)
   ☐ Acute Infusion Reaction Protocol
   ☐ Other ____
7. Monitor patient for 30 minutes post **1st infusion** for hyper/hypotension, dyspnea, nausea, itching, hives, rash and/or wheezing.

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 (non-OMG providers). 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 (non-OMG providers).

Provider Signature: ____ Date: ____________
(NO PROVIDER STAMPS) (Orders expire after 365 days)

Provider's Printed Name: _____________________________________Time: ___________