	<b>Legacy Day Treatment Unit Provider's Orders</b>  Adult Ambulatory Infusion Order ABATACEPT (ORENCIA)	<b>Patient Name:</b> _____ <b>Date of Birth:</b> _____ <b>Med. Rec. No (TVC MRN Only):</b> _____
ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE		

**Anticipated Start Date:** \_\_\_\_\_ **Patient to follow up with provider on date:** \_\_\_\_\_  
**\*\*\*This plan will expire after 365 days, unless otherwise specified below\*\*\***  
**Orders expire:** \_\_\_\_\_

**Weight:** \_\_\_\_\_ kg    **Height:** \_\_\_\_\_ cm

**Allergies:** \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_    **Diagnosis Code:** \_\_\_\_\_

**GUIDELINES FOR PRESCRIBING:**

1. Send **FACE SHEET, INSURANCE CARD and most recent provider chart or progress note**
2. COPD is the most frequent side effect of abatacept therapy. Frequent monitoring is recommended.
3. A tuberculosis screening (Tuberculin skin test or QuantiFERON Gold blood test) must result negative within a year prior to initiation of treatment
4. Hepatitis B (Hep B surface antigen AND core antibody) screening must be completed prior to initiation of therapy and the patient should not be infected

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

- Hepatitis B Surface AG Result Date: \_\_\_\_\_  Positive /  Negative
- Hepatitis B Core AB Qual, Result Date: \_\_\_\_\_  Positive /  Negative
- Tuberculin Test Result Date: \_\_\_\_\_  Positive /  Negative
- QuantiFERON Gold Test Result Date: \_\_\_\_\_  Positive /  Negative

**LABS TO BE DRAWN (orders must be placed in TVC Epic by ordering provider if TVC provider):**


- Basic Metabolic Set, Routine, every \_\_\_\_\_(visit)(days)(weeks)(months) - **Circle one**
- CBC with differential, Routine, every \_\_\_\_\_(visit)(days)(weeks)(months) - **Circle one**
- Other: \_\_\_\_\_

**PRE-MEDICATIONS: (Note: pre-medications are not routinely recommended)**

- acetaminophen (TYLENOL) tablet: 650 mg by mouth, 30 minutes prior to infusion, every visit
- diphenhydramine (BENADRYL) tablet: 25 mg by mouth, 30 minutes prior to infusion, every visit
- cetirizine (ZYTREC) tablet: 10 mg by mouth, 30 minutes prior to infusion, every visit

**(Choose as alternative to diphenhydramine if needed)**

- Other: \_\_\_\_\_ by mouth, 30 minutes prior to infusion, every visit
- No routine pre-medications necessary

 <p>LEGACY HEALTH</p>	<p><b>Legacy Day Treatment Unit Provider's Orders</b></p> <p>Adult Ambulatory Infusion Order ABATACEPT (ORENCIA)</p>	<p><b>Patient Name:</b></p> <p><b>Date of Birth:</b></p> <p><b>Med. Rec. No (TVC MRN Only):</b></p>
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**MEDICATIONS: (must check at least one):**

**Initial Dose:**

abatacept (Orencia) in NaCl 0.9% (total volume 100 mL) IV over 30 minutes, every visit. Administer through a 0.2 to 1.2 micron low protein-binding filter

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

**Interval: (must check one)**

- Once
- Three doses at 0, 2, and 4 weeks

**Maintenance Dose:**

abatacept (Orencia) in NaCl 0.9% (Total volume 100 mL) IV over 30 minutes, every visit. Administer through a 0.2 to 1.2 micron low protein-binding filter

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

**Interval:**

- Every \_\_\_\_\_ weeks for \_\_\_\_\_ doses (beginning at week 8)

**Adjustments for weight changes: (must check one)**


- Contact provider for weight changes impacting recommended dose
- Adjust dose for weight changes impacting recommended dose and notify provider of change

**AS NEEDED MEDICATIONS:**

- acetaminophen 650 mg oral, EVERY 4 HOURS AS NEEDED for headache, fever, chills or malaise
- diphenhydramine 25 mg oral, EVERY 4 HOURS AS NEEDED for itching

**NURSING ORDERS (TREATMENT PARAMETERS):**

1. Assess for any signs of infection prior to each infusion. Hold therapy if positive and notify physician
2. Vital signs, every visit: Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion. Stop infusion immediately if reaction occurs.
3. Nursing communication order, every visit: Manage line per LH policy 904.4007 IV Catheter Insertion (Peripheral) and LH 904.4004 IV Access: Central Catheters
4. Nursing communication orders, every visit: Manage hypersensitivity reactions per LH 906.6606

 <p>LEGACY HEALTH</p>	<p><b>Legacy Day Treatment Unit Provider's Orders</b></p> <p>Adult Ambulatory Infusion Order ABATACEPT (ORENCIA)</p>	<p><b>Patient Name:</b> <b>Date of Birth:</b> <b>Med. Rec. No (TVC MRN Only):</b></p>
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**HYPERSENSITIVITY MEDICATIONS:** Refer to LH policy 906.6606 Initiation of Emergency Measures for Adult Oncology, Radiation Oncology and Infusion Clinic Patients

1. diphenhydramine 25-50 mg IV, AS NEEDED x1 for hypersensitivity reaction
2. famotidine 20 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
3. hydrocortisone 100 mg IV, AS NEEDED x1 dose for hypersensitivity reaction
4. epinephrine 0.3 mg IM, AS NEEDED x1 dose for hypersensitivity reaction
5. naloxone (Narcan) 0.4 mg IV, AS NEEDED x1 dose for diminished respiratory rate
6. sodium chloride 0.9% 1000 mL IV, AS NEEDED x 1 dose for alteration in hemodynamic status
7. Nursing communication order, every visit: Please follow treatment algorithm for acute infusion reaction.

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

**Legacy Day Treatment Unit –  
The Vancouver Clinic Building**  
*A department of Salmon Creek Medical Center*  
700 NE 87<sup>th</sup> Avenue, Suite 360  
Vancouver, WA 98664  
Phone number: 360-896-7070  
Fax number: 360-487-5773

**Legacy Emanuel Day Treatment Unit**  
*A department of Emanuel Medical Center*  
501 N Graham Street, Suite 540  
Portland, OR 97227  
Phone number: 503-413-4608  
Fax number: 503-413-4887

**Legacy Salmon Creek Day Treatment Unit**  
Legacy Salmon Creek Medical Center  
2121 NE 139<sup>th</sup> Street, Suite 110  
Vancouver, WA 98686  
Phone number: 360-487-1750  
Fax number: 360-487-5773

**Legacy STEPS Clinic**  
*A department of Silverton Medical Center*  
Legacy Woodburn Health Center  
1475 Mt Hood Ave  
Woodburn, OR 97071  
Phone number: 503-982-1280  
Fax number: 503-225-8723

**Provider signature:** \_\_\_\_\_

**Date/Time:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Organization/Department:** \_\_\_\_\_