NORMAN REGIONAL Health System

Outpatient Infusion Center

Fax: 405-515-5089
Phone: 405-515-2470

ORD

Abatacept (Orencia)

Patient and Physician Information

Patient Name:	Date of Birth:	Patient Phone Number:
Physician Name:	**Office Phone Number:**	**Fax Number:**
Insurance:	**Group Number:**	**Policy Number:**
Hospitalization Status:	**Patient Weight (kg):**	**Height (inches):**
☑ Outpatient to Outpatient Infusion Center		
Allergies:		

*****Send patient demographics/insurance, clinical notes, and test results with orders*****

Diagnosis Code/Description for treatment: _____

☐ Rheumatoid Arthritis, unspecified (M06.9)

Orders

Initiate IV Vascular Access Flush Orders #0643 for: ☐ Peripheral Line ☐ Midline ☐ PICC ☐ Port
☑ Normal Saline 0.9% Solution 20 milliliter/hour INTRAVENOUS (J7050 : 250 ML = 1 unit)
Other: _____

Premedication

☐ DiphenhydrAMINE (Benadryl) 25 MG ORAL ONCE
☐ Acetaminophen (Tylenol) 325MG 2 TAB ORAL ONCE
Other: _____

Infusion – Abatacept (Orencia) [J0129 : 10 MG = 1 unit]

*******Pharmacy to adjust dosing for Abatacept based on patient's current weight.

FOR patient weighting LESS THAN 60 kg

Abatacept (Orencia) 500 MG in 0.9% Normal Saline Solution to a final volume of 100 mL INTRAVENOUS ONCE over 30 minutes using a 0.2 micron filter PE line tubing (NON-DEHP). Adminster EVERY 2 WEEKS x 3 doses then follow with a maintenance dose EVERY 4 WEEKS.

FOR patient weighting 60 to 100 kg

Abatacept (Orencia) 750 MG in 0.9% Normal Saline Solution to a final volume of 100 mL INTRAVENOUS ONCE over 30 minutes using a 0.2 micron filter PE line tubing (NON-DEHP). Adminster EVERY 2 WEEKS x 3 doses then follow with a maintenance dose EVERY 4 WEEKS.

FOR patient weighting GREATER THAN 100 kg

Abatacept (Orencia) 1000 MG in 0.9% Normal Saline Solution to a final volume of 100 mL INTRAVENOUS ONCE over 30 minutes using a 0.2 micron filter PE line tubing (NON-DEHP). Adminster EVERY 2 WEEKS x 3 doses then follow with a maintenance dose EVERY 4 WEEKS.

Infusion Reaction

☑ If infusion reaction occurs, stop the infusion IMMEDIATELY, notify physician with details of reaction AND initiate the Outpatient Infusion HYPERsensitivity, OIC orders #1024

Discharge

☑ Discharge home 30 minutes after treatment complete if stable.

Date and Physician Signature

DATE:_____ **TIME:**_____ _____
PHYSICIAN'S SIGNATURE

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DO NOT WRITE ON OR BELOW THIS AREA ORDERS MAY BE CUT OFF BY FAX MACHINES