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

PO7071

ADULT AMBULATORY INFUSION ORDER

Abatacept (ORENCIA)

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. 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.
3. A PPD test must have been placed and read as negative within the past year (or QuantiFERON Gold blood test). 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. Patients should have regular monitoring of TB, hepatitis B, and infection throughout therapy. Use with caution in patients with active infection.

OTHER:

☐ Tuberculin (TUBERSOL, APLISOL) injection, 5 units, intradermal, ONCE, Perform prior to initiation of TNF-alpha inhibitor therapy

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

☐ Hepatitis B Surface AG, serum, Routine, ONCE
☐ Hepatitis B Core AB Qual, serum, Routine, ONCE

OR

☐ Hepatitis B surface antigen and core antibody test results scanned with orders

- Tuberculin Test Result. Date: _____ ☐ Positive / ☐ Negative

LABS:

☐ Basic Metabolic Set, 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: _____

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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, oral, ONCE, every visit
  - ☐ 325 mg
  - ☐ 650 mg
  - ☐ 500 mg
  - ☐ 1000 mg
- ☐ diphenhydrAMINE (BENADRYL) capsule, oral, ONCE, every visit
  - ☐ 25 mg
  - ☐ 50 mg
- ☐ loratadine (CLARITIN) tablet, oral, ONCE, every visit
  (Choose as alternative to diphenhydrAMINE if needed)
  - ☐ 5 mg
  - ☐ 10 mg

MEDICATIONS:

Initial Doses:

Abatacept (ORENCIA) in NaCl 0.9% (Total volume 100 mL) IV, ONCE over 30 minutes. Use in-line low protein binding filter (less or equal to 1.2 micron) and infuse 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 NaCl 0.9% (Total volume 100mL) IV, ONCE over 30 minutes. Use in-line low protein binding filter (less or equal to 1.2 micron) and infuse 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)

NURSING ORDERS:

1. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
2. 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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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 (Policy HC-PAT-133-GUD). 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 x1 doses for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction

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**: _____

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OLC Central Intake Nurse:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

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

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave.
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave.
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders