Abatacept (ORENCIA)

**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 infections 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: _______
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
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 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: ______________
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.ohsknight.com/infusionorders](http://www.ohsknight.com/infusionorders)