Fax your completed order to 877-734-1157

Patient Name: ________________________DOB: ____/___/________

Date of Last Infusion: ______/___/________Height___________Weight__________

Infusion Location: (state and site) _____________________________________

Orencia® (abatacept) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_________Psoriatic Arthritis (ICD-10) _________Rheumatoid Arthritis (ICD-10) _________Other: _________________ (ICD-10)

- Hold infusion and notify provider for:
  - Signs or symptoms of illness or active infection
  - Planned/recent surgical procedures or recent live vaccinations
  - Positive Hepatitis B or TB test (must have prior to start)
- Record vital signs before and after infusion
- If an infusion-related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Protocol as clinically indicated

Recommended Dosing;		
❑ Less than 60 kg: 500 mg	❑ 60-100kg: 750mg	❑ Greater than 100kg: 1000mg

Administer ________________mg IV abatacept in 100 mL 0.9% sodium chloride over a period of 30 minutes using a sterile, non-pyrogenic, low protein-binding filter (pore size 0.2 to 1.2 microns).

Frequency (chose one):
□ On Week 0, Week 2, Week 4, then every 4 weeks
□ Every 4 weeks
□ Every __________weeks

Additional Orders:

Provider Name(print): ________________________________ Date:__________________________

Provider Signature: _____________________________________ Time: ___________________________

Reviewed 4/24/23. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.