ABATACEPT (Orencia) Infusion Order Form

REDINGTON-FAIRVIEW GENERAL HOSPITAL
(207) 474-5121 / WWW.RFGH.NET
Skowhegan, Maine 04976

Diagnosis [ ] Rheumatoid arthritis [ ] Psoriatic arthritis, [ ] Other*: _____

Weight: _____kg Height: _____inches [ ] New treatment
[ ] Transfer – Receiving Abatacept since_____

Negative TB test date _____

- Screen for Hepatitis B infection: Hep B surface antigen, Hep B Antibody, Hep B Core Antibody total. .
- TB screen with PPD or IGRA before start of therapy if none in past 12 months. Repeat every 12 months. Notify provider of positive results.

PRE-MEDICATE (30 minutes before infusion) **or confirm patient has taken prior to arrival**

[ ] acetaminophen 1000 mg PO
[ ] loratadine 10 mg PO
[ ] diphenhydramine 25 mg PO
[ ] Methylprednisolone 40 mg IV
[ ] Hydrocortisone 50 mg IV
[ ] Other:

Abatacept IV

[ ] 500 mg - patient weight < 60 kg
[ ] 750 mg - patient weight 60 to 100 kg
[ ] 1000 mg - patient weight > 100 kg

[ ] Initiating treatment: Weeks 0,2,4, then every 4 weeks
[ ] Ongoing treatment: Every 4 weeks.

Screen patient for symptoms of current infection. Defer treatment and contact prescriber if noted.
Instruct patient to report any symptoms of discomfort or an allergic reaction immediately.
Administer diluted in 100 mls sodium chloride 0.9%.
Infuse over 30 minutes for rheumatoid or psoriatic arthritis. *Consult pharmacy for other indications.
Infuse through a 0.2 to 1.2-micron low protein binding filter.
Vital Signs: prior to infusion, at 15 minutes, and post infusion. Patient may be discharged if post-infusion vital signs are stable. Instruct patient to seek medical attention if they feel sick or develop a fever, cough, or other signs of infection.

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] complete [ ] not needed#
#If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Duration of authorization:_____

Checklist for non-RFGH credentialed providers:
Annually:
[ ] H&P completed with last year **[ ]** Copy of most recent TB test result (if none, IGRA will be done in clinic)
If new therapy:
[ ] Hep B screen or document of vaccination [ ] Documentation supporting diagnosis and prior therapies
[ ] Problem list, current medication and allergies attached
[ ] Provider to provider communication is required. If the patient has a Primary Care Provider at RFGH, please contact that PCP. Otherwise, call (207) 474-5121 and ask to speak to hospitalist .
Contacted provider:_____

FAX to RFGH Infusion clinic at 207-858-2404 Contact Infusion Clinic at 207-858-8722

Prep: 4/28/25

Provider signature _____Date_____time_____

If not RFGH credentialed: Printed name_____ Phone # _____

RFGH Co-signature _____

Date_____ time:_____

Patient _____

dob_____ phone #_____