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.