Novella Infusion

Patient Name:
DOB:
Date of Last Infusion
Insurance:

Clinic Location:
Merrimack, NH ☐
Concord, NH ☐

Abatacept (Orencia®) Infusion Orders

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

_____ Rheumatoid Arthritis (ICD-10)

_____ Psoriatic Arthritis (ICD-10)

_____ Juvenile Idiopathic Arthritis (ICD-10)

_____ Other: _____ (ICD-10)

Nursing:

- Hold infusion and notify provider for
  - Signs or symptoms of illness or active infection
  - Planned/recent surgical procedures
  - Recent live vaccinations
- Monitor vital signs before and after infusion.
- If infusion-related reaction occurs, stop infusion, notify provider and follow Hypersensitivity Reaction Management Protocol as clinically indicated.

Dose: **Administer _____ mg 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: _____

Revised 2/7/2020

(order valid for one year unless otherwise indicated)