

Orencia (Abatacept) Infusion Order

Patient Name: _____ DOB: _____ Male Female

Diagnosis (please provide ICD10 code) _____

Other: _____

NKDA Allergies: _____

New Start Therapy Continuation of Therapy Date of last dose (if applicable): _____

Ordering Provider:

Provider NPI: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

PRE-MEDICATION

- Acetaminophen 1000mg PO Solu-Medrol 125mg IVP
 Diphenhydramine 25mg PO Solu-Cortef 100mg IVP
 Ceterizine 10mg PO Diphenhydramine 25mg IVP

REQUIRED LABS

- TB status and date (please attach results):

 Hepatitis B status & date (please attach results):

SIMPONI ARIA ORDERS

DOSING:

- Mix in 100ml 0.9% sodium chloride and administer intravenous infusion over 30 minutes

Dose: 500mg 750mg 1000mg Other: _____ mg

FREQUENCY:

- Induction and Maintenance:** Week 0, 2, and 4, then every 4 weeks
 OR Maintenance Only: every 4 weeks
 Other: _____

REFILLS:

(if not indicated prescription will expire one year from date signed)

Sage Infusion Standing Orders:

- Provide treatment under Sage Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name

Provider Signature

Date