Trinity Health Muskegon & Shelby Infusion Clinics
Muskegon: 1500 Sherman BLVD, Muskegon, MI 49444
Shelby: 72 S. State St. Shelby, MI 49455
Fax: 231-727-4328

Abatacept (Orencia®)

With Fax Include: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. Trinity Health Muskegon will obtain any necessary medication authorizations for patients receiving infusion therapies

Order Date: ____/____/____ **Site of Service:** ☒ TH Muskegon

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____
Date of Birth: ____/____/____
Weight: _____kg **Height:** _____cm
Allergies: _____

Primary Insurance: _____
Member ID: _____
Secondary Insurance: _____
Member ID: _____

Diagnosis
Diagnosis Code (ICD-10):_____
Indication: _____
Target start date: _____

Labs
No labs required. Labs to be ordered by physician.
☐ CBC
☐ Other: _____

Date of negative Tuberculosis Screen: _____ **Date of Negative Hepatitis Screen: _____**

Hold and Notify Provider: Signs and symptoms of active infection.

Pre-medications: No routine pre-medications are routinely given. Pre-medications may be ordered at physician discretion.

☐Acetaminophen	650mg	Oral
☐ Loratadine	10mg	Oral
☐ Diphenhydramine	50mg	☐ Oral ☐ IV
☐ Famotidine	20mg	☐ Oral ☐IV
☐ Hydrocortisone	100mg	IV
☐ Methylprednisolone	125mg	IV

℞ **Abatacept (Orencia®) _____** mg IVPB over 30 minutes.

☐ < 60 kg: 500mg
☐ 60 to 100 kg: 750mg
☐ > 100 kg: 1,000mg
☐ Pharmacy to adjust dose based on treatment day weight.

☐ **Induction: 0, 2, and 4 weeks**
☐ **Maintenance: Every 4 weeks x 1 year (beginning 4 weeks after last induction dose)**

Note to nurses:
Administer with 0.2 micron low-protein binding filter. NS flush only.

Nursing orders:
Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy if necessary: sodium chloride 0.9 % bolus 500 mL PRN; acetaminophen tablet 650 mg PRN; albuterol 2.5 mg /3 mL (0.083 %) nebulizer solution 2.5 mg PRN; albuterol HFA inhaler 2 puff PRN; epinephrine injection 0.3 mg PRN; famotidine injection 20 mg PRN; diphenhydramine injection 50 mg PRN; diphenhydramine injection 25 mg PRN; hydrocortisone sodium succinate injection 100 mg PRN

Provider Name: _____ Provider Signature: _____
Office Phone Number: _____ Office Fax Number: _____
Attending Physician Name: _____
(If ordering provider is an advanced practice practitioner, attending physician required)
Note: This order is valid for 12 months from date of physician signature.