Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____

Current Height: _____ Current Weight_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Related Diagnosis Code (ICD-10 code): _____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Orencia® (abatacept) RA Treatment Plan (Adult)

Patient Name: _____ **Patient DOB** _____

General

☐ Diagnosis- Seropositive Rheumatoid Arthritis multiple sites ICD-10 Code _____
☐ Diagnosis- Seronegative Rheumatoid Arthritis multiple sites ICD-10 Code _____
☐ Diagnosis- Psoriatic Arthritis ICD-10 Code _____
☐ Diagnosis- Other _____ ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

Authorized Treatment Duration ☐ 12 Months ☐ Other _____

Infusion (Month 1 to 12) Duration: 12 Months

☑ Vital Signs (Month 1 to 12)
every 30 min, Resp, BP, HR, Temperature on admission to the unit and prior to infusion HR, BP every 30 minutes during the infusion and prior to discharge

Pre- Treatment & PRN Medications

Tylenol (Month 1 to 12)

☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before abatacept dose

Benadryl (Month 1 to 12)

☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before abatacept dose

☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before abatacept dose

SOLU-Medrol (Month 1 to 12)

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before abatacept dose

Zofran (Month 1 to 12)

☐ *2 mg, IV, every 4 hr, PRN nausea* (DEF)*
☐ *4 mg, IV, every 4 hr, PRN nausea*

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

Orencia® (abatacept) RA Treatment Plan (Adult)

☐ **Loading Dose abatacept** (week 0,2,4)

- ☐ **Weight less than 60kg** -- *500 mg, IV Piggyback,*
  Comments: Compounded in 100mL NS. Infuse over 30 minutes via 0.22 micron filter
- ☐ **Weight 60kg to 100.0kg**-- *750 mg, IV Piggyback,*
  Comments: Compounded in 100mL NS. Infuse over 30 minutes via 0.22 micron filter
- ☐ **Weight greater than or equal to 100.01kg**--*1,000 mg, IV Piggyback,*
  Comments: Compounded in 100mL NS. Infuse over 30 minutes via 0.22 micron filter

☐ **Maintenance Dose abatacept** (Every 4 weeks)

- ☐ **Weight less than 60kg** -- *500 mg, IV Piggyback,*
  Comments: Compounded in 100mL NS. Infuse over 30 minutes via 0.22 micron filter
- ☐ **Weight 60kg to 100.0kg**-- *750 mg, IV Piggyback,*
  Comments: Compounded in 100mL NS. Infuse over 30 minutes via 0.22 micron filter
- ☐ **Weight greater than or equal to 100.01kg**--*1,000 mg, IV Piggyback,*
  Comments: Compounded in 100mL NS. Infuse over 30 minutes via 0.22 micron filter

☑ Communication Order (Month 1 to 12)
Patient must stay in infusion area for 30 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician. Patient should be accompanied by another adult upon discharge

☑ Communication Order (Month 1 to 12)
Ensure negative PPD or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, Pruritis, urticaria, persistent flushing Temperature > 100 or HR <50 or > 130

☑ Notify Provider (Month 1 to 12)
For POSITIVE results of PPD test or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Labs (Month 1 to 12) Duration: 12 Months

☑ Quantiferon(R)-TB Gold, 4T, Incu-(36971) (If Needed)

☑ CBC w/ Diff (If Needed)

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

☐ Biosimilar Substitution **NOT** permitted

Orencia® (abatacept) RA Treatment Plan (Adult)

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____

☐ Biosimilar Substitution **NOT** permitted