

- NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4589; Fax: 207-768-4183
- NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970
- NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801
- NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788
- NL Infusion Care, **Waterville**
Phone: 207-861-3380; Fax: 207-861-3348

- NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485
- NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418
- NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917
- NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

OP abatacept (Orencia) (Paper)

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- Diagnosis:** Psoriatic arthritis
 Rheumatoid arthritis

ICD10: _____

Verification of T SPOT or Quantiferon: TB testing is required prior to initiation of therapy, a change in living environment, or travel to an area that would pose an increased risk of TB. Please indicate date and result of test done:

T SPOT: Date: ____/____/____ Result: _____

Quantiferon TB Gold Test: Date: ____/____/____ Result: _____

Hepatitis B and C Testing:

Hepatitis B: Date: ____/____/____ Result: _____

Hepatitis C: Date: ____/____/____ Result: _____

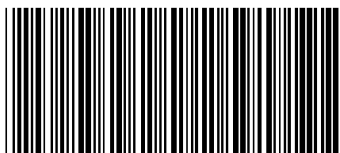
IV Access:

- Saline Lock:
 - Insert peripheral Saline Lock; *may leave in for consecutive treatment days*
 - Discontinue Saline Lock after therapy completed
- PICC Line:
 - Routine PICC Line Care, labs and restoration
 - Discontinue PICC Line (verify regimen is complete with provider prior to removing line)
- Porta cath / Central Access Device (Hickman, Triple lumen):
 - Porta cath access, labs, restoration and de-access / Central Access Device use and care

Height: _____ cm **Weight:** _____ kg

Premedication:

- Acetaminophen (Tylenol) 650 mg, PO, ONCE
- Cetirizine (Zyrtec) 10 mg, PO, ONCE
- methylPREDNISolone 40 mg, Soln, IVP, ONCE
- methylPREDNISolone 125 mg, Soln, IVP, ONCE
- methylPREDNISolone _____ mg, Soln, IVP, ONCE



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Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS
March 2025

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Medication:

Abatacept (Orencia)

_____ mg, IVPB, Every 14 day interval, 3 doses/times, Infuse over 30 minutes using an infusion pump and a sterile non-pyrogenic low protein binding filter (pore size 0.2 – 1.2 microns), Loading Doses

Usual loading dosage: (250 mg = 1 vial)

Less than 60 kg	500 mg (2 vials) (weeks 0, 2, and 4 for 3 dose loading)
60 – 100 kg	750 mg (3 vials) (weeks 0, 2, and 4 for 3 dose loading)
Greater than 100 kg	1000 mg (4 vials) (weeks 0, 2, and 4 for 3 dose loading)

Abatacept (Orencia)

_____ mg, IVPB, every 4 weeks, Infuse over 30 minutes using an infusion pump and a sterile non-pyrogenic low protein binding filter (pore size 0.2 – 1.2 microns)

_____ mg, IVPB, Once, Infuse over 30 minutes using an infusion pump and a sterile non-pyrogenic low protein binding filter (pore size 0.2 – 1.2 microns), Loading Dose

Usual dosage: (250 mg = 1 vial)

Less than 60 kg	500 mg (2 vials)
60 – 100 kg	750 mg (3 vials)
Greater than 100 kg	1,000 mg (4 vials)

Duration: 6 months 1 year Other: _____

Other:



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Date: _____ Time: _____

Provider Signature: _____ Print Name: _____

Phone: _____ Fax: _____

Pharmacy Signature: _____

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