LOWER UMPQUA HOSPITAL
HOSPITAL DISTRICT

LOWER UMPQUA HOSPITAL
OUTPATIENT NURSING DEPARTMENT
600 Ranch Road, Reedsport, OR 97467
For Referrals: (541) 271-2163 – Press #3 (all other services) then press # 2 (Referrals)
For Outpatient Nursing: (541) 271-2171 ext. 5205
FAX: (541) 271-5433

ABATECEPT *(ORENCIA)*

Patient Name _____ **DOB** _____

Patient Phone # _____ **Patient Weight (Kg)** _____ **Patient Height (cm):** _____

Patient Allergies _____

Provider _____ **NPI#** _____

ICD-10 Code (REQUIRED) _____ **J Code** _____

Primary Diagnosis _____

Secondary Diagnosis _____

Duration (or # of treatments): _____ **Anticipated Infusion Date** _____

INSTRUCTIONS TO PROVIDER:

- *This plan will expire **after 365 days**, at which time new orders will need to be placed.*

MEDICATIONS:

☐ **Induction + Maintenance Dosing: abatacept** *(ORENCIA)* _____ mg in **sodium chloride 0.9%** 100 mL IV infusion - infuse over 30 minutes. Low protein binding 0.2 to 1.2 micron inline filter required.

Dosing instructions: less than 60 Kg = 500 mg; 60 to 100 Kg = 750 mg; **greater than** 100 Kg = 1000 mg

- Induction: administer once every 2 weeks on weeks 0, 2, 4
- Maintenance: administer 4 weeks after induction and once every 4 weeks thereafter

☐ **Maintenance Dosing: abatacept** *(ORENCIA)* _____ mg in **sodium chloride 0.9%** 100 mL IV infusion - infuse over 30 minutes. Low protein binding 0.2 to 1.2 micron inline filter required.

Dosing instructions: less than 60 Kg = 500 mg; 60 to 100 Kg = 750 mg; **greater than** 100 Kg = 1000 mg

☐ Administer every 4 weeks

☐ Administer every _____ weeks

ORDERING GUIDELINES:

☒ Send **FACE SHEET and H&P or most recent chart note**

☒ PRIOR to initiation, proof of negative results REQUIRED from Hepatitis B screening and TB test (PPD or QuantiFERON Gold). Assess for infection prior to initiating infusion and during therapy. Use caution with COPD (higher incidences of adverse effects and COPD exacerbations have been observed) and monitor closely.

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Date _____ Time _____ Provider Signature _____

"Statement of Responsibility of Parties: referring Prescriber agrees that in referring patients to Lower Umpqua Hospital Outpatient Nursing Department, the responsibility for the care related to these Outpatient Nursing Therapy Plan orders, as well as administration of any 340B drugs, remains with Lower Umpqua Hospital."

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ABATECEPT *(ORENCIA)*

Patient Name _____ **DOB** _____

PRE-MEDICATIONS *(Administer 30 to 60 minutes prior to each infusion)*:

- ☐ **acetaminophen** 650 mg PO **x** 1
- ☐ **diphenhydrAMINE** *(BENADRYL)* 25 mg PO **x** 1. If cannot tolerate oral, may give IV.
  **Give either loratidine or Benadryl, not both.*
- ☐ **diphenhydrAMINE** *(BENADRYL)* 25 mg IV **x** 1 PRN if cannot tolerate PO.
  **Give either loratidine or Benadryl, not both.*
- ☐ **loratidine** *(CLARITIN)* 10 mg PO **x** 1 PRN if diphenhydramine not given.
  **Give either loratidine or Benadryl, not both.*
- ☐ **methylPREDNISolone sodium succinate** *(SOLU-Medrol)* 40 mg IV **x** 1.
  Administer prior to infusion over 5 minutes.
  **Give with each infusion IF patient has a history of infusion/hypersensitivity reaction*.

TREATMENT PARAMETERS:

- ☒ Monitor for infection and instruct patient to report any signs or symptoms.
  Hold infusion and NOTIFY provider for:
  - temperature **greater than** 100.4°F,
  - complaints of symptoms of acute viral or bacterial illness, or
  - patient is taking antibiotics for current infection.

HYDRATION:

- ☒ **sodium chloride 0.9%** *(NORMAL SALINE)* 100 mL at rate of IVPB (flush rate is to the be the same as IVPB infusion rate) PRN IVPB Flush

LINE CARE MAINTENANCE:

- ☒ **alteplase** *(CATHFLO ACTIVASE)* 2 mg IVP **x** 1 PRN cathether occlusion.
  May repeat x 1 dose after 2 hours of administration if catheter still occluded
- ☒ **heparin, porcine** (PF) 100 units/mL IV syringe 500 units intra-catheter **x** 1 PRN line care
- ☒ **sodium chloride 0.9%** flush, 10 mL IV - PRN flush
- ☒ If applicable, may remove PICC line at the completion of course of therapy

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ABATECEPT *(ORENCIA)*

Patient Name _____ **DOB** _____

EMERGENCY MEDICATIONS FOR HYPERSENSITIVITY / INFUSION REACTION:

** *Itching, hives, fever* **

- ☒ **STOP MEDICATION INFUSION if allergic reaction occurs**
- ☒ Establish IV access and infuse **0.9% sodium chloride** 500 mL at 25 mL/hour PRN Hypersensitivity / Allergic reaction
- ☒ VS Q15 minutes **x** 4 and PRN
- ☒ **acetaminophen** *(TYLENOL)* 650 mg PO Q4HRS PRN Hypersensitivity / Allergic Reaction.
- ☒ **diphenhydramine** *(BENADRYL)* 25 mg IVP PRN Hypersensitivity / Allergic Reaction **x** 1 dose
  May repeat **x** 1 ***{Maximum dose = 50 mg}***
- ☒ **NOTIFY** Provider of Hypersensitivity / Allergic Reaction
- ☒ **hydrocortisone** 100 mg IVP PRN Hypersensitivity / Allergic Reactions **x** 1 dose if reaction continues and is not relieved by maximum dose of **diphenhydramine**

ANAPHYLAXIS REACTION:

** *Wheezing, Dyspnea, Hypotension, Angioedema, Chest pain, Tongue swelling* **

- ☒ Transfer to Emergency Department (ED) as needed, and **NOTIFY** Provider
- ☒ **epinephrine** 0.3 mg IM PRN anaphylaxis **x** 1 dose

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