




<p style="text-align: center;">THE UNIVERSITY OF KANSAS HOSPITAL <b>KUMED</b> 3901 Rainbow Boulevard Kansas City, Kansas 66160</p>	<p>Do not write in this box</p>  <b>DT0017</b>	<p>PATIENT LABEL</p>
<b>PHYSICIAN'S ORDER FORM</b>		

DATE & TIME	#	<b>ORDERS</b> <b>ABATACEPT (ORENCIA®)</b>
		<b>Reference:</b> <a href="http://www.abatacept.com">www.abatacept.com</a> accessed 2/29/2008.
		<b>Order Initiation Date:</b> _____ (Expires 6 months from initiation date) <b>Patient Weight:</b> _____ kg
	1.	Attending Physician: _____ Pager: _____ Resident Physician: _____ Pager: _____
	2.	<b>Diagnosis:</b>
	3.	<b>ICD 9Code:</b>
	4.	<b>Indications:</b>
	5.	<b>Allergies:</b>
	6.	<b>Labs to be drawn prior to infusion:</b>  <b>Nursing:</b> <ul style="list-style-type: none"> <li>• Obtain patient's VS prior to and at the completion of the infusion.</li> <li>• Assess for any medication reaction after last infusion.</li> <li>• Insert 22 gauge or 24 gauge peripheral IV and saline lock.</li> <li>• If the patient has a reaction to the medication, take the VS every 15 minutes until the patient has no signs or symptoms of the medication reaction.</li> <li>• Do not shake medication.</li> <li>• Do not use if opaque, translucent, discolored, or foreign particles are visualized.</li> <li>• Must be given through a sterile, nonpyrogenic, low-protein-binding filter.</li> </ul>
	7.	<b>Pre-medication orders:</b> <input type="checkbox"/> Loratadine (Claritin) 10mg PO x 1, or equivalent oral anti-histamine <input type="checkbox"/> Acetaminophen (Tylenol) 1000mg PO x 1
	8.	<b>IV Fluids:</b> <ul style="list-style-type: none"> <li>• Flush the IV site with 10mL NS prior to and at the completion of the infusion.</li> </ul>
	9.	<b>Medications:</b> <input type="checkbox"/> <b>Initiation:</b> Intravenous Abatacept 10 mg/Kg IV to infuse over 30 minutes on Day 1, Day 15, Day 30, then every 4 weeks X 6 months (pharmacy to round to nearest 250mg vial size) <input type="checkbox"/> <b>Maintenance:</b> Intravenous Abatacept 10 mg/Kg IV to infuse over 30 minutes every 4 weeks X 6 months (pharmacy to round to nearest 250mg vial size)
	10.	Call Physician _____ Pager _____ for: <ul style="list-style-type: none"> <li>• Temperature &gt;38.5° C</li> <li>• Pulse &lt;60 or &gt; 120 BPM</li> <li>• Respirations &lt;12 or &gt;35 Breaths per minute</li> <li>• SaO<sub>2</sub> &lt; 92% or increased O<sub>2</sub> needs</li> <li>• SBP &lt;90 or &gt;160; DBP &lt;50 or &gt;100; MAP of 60</li> <li>• FSBS &lt;60 or &gt;300 mg/dL</li> </ul> <p><b>Notify the physician immediately for any new onset of the following:</b> hives, swollen face, eyelids, lips, tongue, throat, or trouble breathing, headache, nausea, sore throat.</p> <p><b>STOP the infusion immediately, administer reaction management medications , call rapid response/code team as appropriate and notify the physician for any new onset of the following life threatening hypersensitivity reaction to include:</b> urticaria, hypotension, dyspnea, hypoxia, anaphylaxis.</p>

