Columbus Community Hospital

Columbus, Nebraska

DOCTORS ORDERS

PLEASE NOTE: Condition of Wound, Removal of Stitches, Consultation, Change in Diagnosis, Complications, Condition on Discharge, Instructions of Patient.

PLEASE SIGN AND DATE EACH ENTRY

PLEASE INDICATE / ALLERGIES

NONE	CODEINE	PENICILLIN	SULFA	ASPIRIN	OTHER	HEIGHT
REACTION						WEIGHT

Authorization is granted to supply medications by non-proprietary name unless checked here ☐

PHYSICIANS ORDERS (including Medications)

Diagnosis Code: ______________________

Treatment Start Date: ___________________Patient to follow up with provider on date: ______________________

This plan will expire after 365 days at which time a new order will need to be placed

GUIDELINES FOR ORDERING:

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.
3. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
4. COPD is the most frequent side effect of abatacept therapy. Providers should, inform patients with COPD of the risk for exacerbation and consider excluding them from therapy. At a minimum, frequent monitoring is recommended.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- ☐ Hepatitis B surface antigen and core antibody total test results scanned with orders.
- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:

- ☐ Complete Metabolic Panel, Routine, ONCE, every___________ (visit)(days)(weeks)(months) – Circle One
- ☐ CBC with differential, Routine, ONCE, every________________ (visit)(days)(weeks)(months) – Circle One
- ☐ Labs already drawn. Date: _________________

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes.
4. VITAL SIGNS – Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion

(cont.)

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PHYSICIANS ORDERS (including Medications)

Abatacept (ORENCIA) Orders

PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

- ☐ acetaminophen (TYLENOL) 650 mg orally ONCE every visit
- ☐ diphenhydrAMINE (BENADRYL) 50 mg orally ONCE every visit
- ☐ loratadine (CLARITIN) 10 mg orally ONCE AS NEEDED if diphenhydrAMINE is not given, every visit.

Give either loratadine or diphenhydrAMINE, not both.

MEDICATIONS:

Dose:

Abatacept (ORENCIA) in sodium chloride 0.9% (Total volume 100 mL) intravenous, ONCE over 30 minutes. Use a sterile, non-pyrogenic, low protein-binding filter (0.2-1.2 microns).

- ☐ 500 mg – Patient weight less than 60 kg
- ☐ 750 mg – Patient weight 60-100 kg
- ☐ 1000 mg – Patient weight greater than 100 kg

Interval: (must check one)

- ☐ Once
- ☐ Three doses at 0, 2, and 4 weeks; dates: Week 0______, Week 2______, Week 4______.
- ☐ Every ______ weeks for ____ doses (Beginning at week 8 = every 4 weeks, at least 28 days apart)

HYPERSENSITIVITY:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop **STOP THE INFUSION**.
2. Obtain vital signs and continue to monitor vitals every 5 minutes.
3. Notify ordering provider.
4. Refer to **Adult Hypersensitivity (HSR) & Allergic Reaction Management** algorithm for assessment guidelines and interventions.
5. Continue to assess as grade of severity may progress.
6. Administer emergency medications as directed on the physician's orders.

HYPERSENSITIVITY MEDICATIONS:

- **Acetaminophen**, **975 mg**, PO, x 1 dose, AS NEEDED for hypersensitivity or infusion reaction.
- **DiphenhydrAMINE inj, 50 mg**, IV, AS NEEDED for hypersensitivity or infusion reaction. May repeat x 1 AS NEEDED per reaction management algorithm.
- **Hydrocortisone Sodium Succinate, 100 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Famotidine, 20 mg**, IV, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.
- **Oxygen, 2 Liters/min** per nasal cannula for hypersensitivity or infusion reaction.
- **0.9% Normal Saline, 1000 mL**, IV, 150mL/hr, AS NEEDED for hypersensitivity or infusion reaction.
- **EPINEPHrine HCl (1mg/1mL), 0.3 mg**, IM injection, AS NEEDED x 1 dose for hypersensitivity or infusion reaction.

(cont.)

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Abatacept (ORENCIA) Orders

My NPI number is ______________________________ **(MUST BE COMPLETED TO BE A VALID PRESCRIPTION)**; and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: ____ Date/Time: ___________________

Printed Name: ______________________________ Phone: ________________Fax: __________________