



Preferred Clinic Location

- ☐ **Harbor Health Park Bend Clinic**
2200 Park Bend Drive, Bldg. 2, Suite 204, Austin, TX 78758
P: (512) 270-2104
F: (512) 233-2288

Patient Information

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Date: _____ Patient Name: _____ DOB: _____
ICD-10 code (required): _____ ICD-10 description: _____
☐ NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____
Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

Provider Information

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

Supporting Documents/Information (Please provide all of the following)

- Patient insurance information
- Patient medication list
- Supporting clinical notes (H&P) to support primary diagnosis:
 - TB status & date (list results here & attach clinicals)
 - Hep B status & date (list results here & attach clinicals)

Orders

NURSING

- ☒ Nursing care per Harbor Health nursing procedures and [Harbor Health Adverse Reaction Management Protocol](#).
☒ Verify TB status and date (Please provide results)
☒ Verify Hepatitis B status and date (Please provide results)
☐ Adjustments for weight changes (must check one)
 - ☐ Keep ordered dose regardless of weight change at infusion center visit
 - ☐ Contact provider for weight changes impacting recommended dose
 - ☐ Adjust dose for weight changes impacting recommended dose and notify provider

LABORATORY

- ☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION

- ☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO

- ☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____ Frequency: _____

THERAPY

- ☐ **Abatacept** (Orencia) in 100ml 0.9% sodium chloride, intravenous infusion over 30 minutes (use in line filter 0.2 to 1.2 micron)
 - Dose: ☐ <60kg: 500mg ☐ 60-100kg: 750mg
☐ >100kg: 1000mg ☐ other _____mg
 - Frequency: ☐ induction: week 0, 2, and 4, then every 4 weeks
☐ maintenance: every 4 weeks
☐ other _____
 - Route: ☒ Intravenous
 - Infuse over 30 minutes
 - Remove equal volume from bag prior to adding medication
☒ Flush with 0.9% sodium chloride at infusion completion

☐ Patient is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

**Screen for latent TB infection prior to initiating therapy. Patients testing positive should be treated prior to initiating ORENCIA.*

Provider Name (Print): _____

Provider Signature: _____

Date: _____