Place Sticker Here

Abatacept (Orencia) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one and complete the 2nd and 3rd digits to complete the ICD-10 code):

□ M05.___ Rheumatoid Arthritis with Rheumatoid factor

□ M06.___ Rheumatoid Arthritis without Rheumatoid factor

□ Other: ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

□ None

□ Acetaminophen 650 mg PO

□ Diphenhydramine: Dose: □ 25 mg □ 50 mg Route: □ PO or □ IVP

□ Methylprednisolone: Dose: □ 40 mg or □ 125 Route: IVP

□ Famotidine: Dose: 20 mg Route: □ PO or □ IVPB

□ Other (include drug, dose, and route): _____

Drug Orders:

- Abatacept (Orencia) (J0129) per 100 mL Sodium Chloride 0.9% IV to infuse over 30 minutes
- Dose: □ Weight < 60 kg: 500 mg
  □ Weight of 60-100 kg: 750 mg
  □ Weight > 100 kg: 1000 mg
- Frequency: □ Induction: Weeks 0, 2, and 4 then every 4 weeks thereafter
  □ Maintenance: every 4 weeks
  □ Other: _____
- Order Duration: Six months unless otherwise specified (Other: _____)

Lab Orders:

□ _____

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Pre-Screening Requirements:

- Provide TB screening results (PPD or QuantiFERON Gold Test) prior to start of therapy and within last 12 months
- Provide Hepatitis screening (Hepatitis B Surface Antigen) prior to start of therapy and within last 12 months

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received abatacept at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____

and the last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Florence: 843-777-6001 (Fax)

843-777-4655 (Phone)