

McLeod Health

Abatacept (Orencia) Treatment Plan

Patient Name: _____ DOB: _____

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

Patient Primary Phone Number: _____

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**

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: One year 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.

• Appropriate access and line care orders per health system policy

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 Information:

Insurance Plan Name: _____

Insurance Identification Number: _____

Insurance Customer Service Contact Number: _____

Preferred Treatment Location

<input type="checkbox"/> McLeod Regional Medical Center (Florence)	<input type="checkbox"/> McLeod Health Loris	<input type="checkbox"/> McLeod Health Cheraw
<input type="checkbox"/> McLeod Health Seacoast (Little River)	<input type="checkbox"/> McLeod Health Dillon	<input type="checkbox"/> McLeod Health Clarendon (Manning)

Fax completed Treatment Plan to the McLeod Medication Access Team at 843-777-9798. For any questions, please contact our team at medicationaccessteam@mcleodhealth.org.