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: 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:** _____

Approved: 02/2022, Last Reviewed: 01/2025

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

☐ McLeod Regional Medical Center (Florence) ☐ McLeod Health Loris ☐ McLeod Health Cheraw

☐ McLeod Health Seacoast (Little River) ☐ McLeod Health Dillon ☐ 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.