Tocilizumab (Actemra)

Provider Order Form rev. 01/02/2024

PATIENT INFORMATION

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

Patient Name: DOB: Patient Phone:

Patient Address: Patient Email:

Allergies: ☐ NKDA Weight (lbs/kg): Height (in/cm):

Sex: ☐ M / ☐ F Date of Last Infusion: Next Due Date: Preferred Location:

DIAGNOSIS *(Please provide ICD-10 code in space provided)*

Rheumatoid Arthritis: Cytokine Release Syndrome: Giant Cell Arteritis:

Systemic Sclerosis Interstitial lung disease: Other:

THERAPY ADMINISTRATION

☑ Administer tocilizumab (Actemra) in 100ml of 0.9% NS over 60mins

DOSING *(Choose one)*

☐ RA/CRS: 4mg/kg x (_____ kg) = _____ mg
(Max dose should not exceed 800mg per infusion)
☐ RA/CRS: 8mg/kg x (_____ kg)= _____ mg
(Max dose should not exceed 800mg per infusion)
☐ GCA: 6mg/kg (_____ kg)= _____ mg
(Max dose should not exceed 600mg per infusion)
☐ OTHER: _____
(Max dose should not exceed 800mg per infusion)

FREQUENCY *(Choose one)*

☐ Every 4 weeks
☐ Every _____ weeks

ADDITIONAL ORDERS

LABORATORY ORDERS

☑ CBC w/diff, AST, ALT at Week 4, then every 3 months
☑ Lipid Panel at Week 4, then every 6 months

PRE-MEDICATION ORDERS

☐ Tylenol ☐ 500mg / ☐ 650mg PO
☐ Loratadine 10mg PO
☐ Pepcid 20mg ☐ PO / ☐ IVP
☐ Benadryl ☐ 25mg / ☐ 50mg ☐ PO / ☐ IVP
☐ Solumedrol ☐ 40mg / ☐ 125mg IVP
☐ Other: _____

NURSING

☑ Hold infusion and notify provider for:

- Signs or symptoms of illness or active infection.
- Planned/recent surgical procedures or recent live vaccines.
- New abdominal pain, fatigue, anorexia, dark urine, jaundice or neurological changes.
- For therapy continuation, ANC at least 1000 mm^3
- For initial therapy, ANC at least 2000mm^3
- PLT at least to 100,000 mm^3
- AST or ALT no greater than 1.5 times normal level

☑ Measure and record weight at each appointment
☑ Provide nursing care per Nursing Procedure, including Hypersensitivity Reaction Management Protocol and post-procedure observation

PROVIDER INFORMATION

Preferred Contact Name: Preferred Contact Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

REQUIRED DOCUMENTATION CHECKLIST *(Additional documentation required for processing and insurance approval)*

Required Documentation: Patient demos, copy of front and back of primary and secondary insurance, 2 most recent OVN including treatment failures or contraindications, biologic agents, steroids, and disease modifying agents
Required Labs: Negative Hepatitis B, Negative TB within 12 months, Rheumatoid factor, CRP, ESR, ANC, ALT, AST, Platelets

Provider Name *(print)* **Provider Signature** **Date**

Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.