

# 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<sup>3</sup>
- For initial therapy, ANC at least 2000mm<sup>3</sup>
- PLT at least to 100,000 mm<sup>3</sup>
- 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.