Fax Form to: 330-294-2082

INDY INFUSION

Tocilizumab (Actemra)

Provider Order Form *rev. 10/12/2022*

PATIENT INFORMATION

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

Date: Patient Name: DOB:

ICD-10 code (required): ICD-10 description:

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

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Last Treatment Date: Next Due Date:

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

NURSING

☑ TB status & date (list results here & attach clinicals)

☑ Provide nursing care per Nursing Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg / ☐ 650mg / ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg / ☐ 50mg ☐ PO / ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg / ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____
Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☐ **Tocilizumab** (Actemra) in 100ml 0.9% sodium chloride for patient weight >30kg or 50ml 0.9% sodium chloride for patient weight <30kg, intravenous infusion over one hour
- Dose: ☐ 4mg/kg / ☐ 8mg/kg / ☐ 10mg/kg / ☐ 12mg/kg / ☐ _____mg/kg

☐ round up to nearest whole vial
☐ give exact dose
- Frequency: ☐ every 2 weeks / ☐ every 4 weeks / ☐ other: _____
- Route: ☑ intravenous
- Infuse over 1 hour

☑ Flush with 0.9% sodium chloride at infusion completion

☐ **Tocilizumab** (Actemra) injection
- Dose: ☐ 162mg / ☐ _____mg
- Frequency: ☐ weekly / ☐ every 2 weeks / ☐ every 3 weeks / ☐ other: _____
- Route: ☑ subcutaneous

☐ Patient is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

Perform test for latent TB; if positive, start treatment for TB prior to starting ACTEMRA. Monitor all patients for active TB during treatment, even if initial latent TB test is negative.

It is recommended that ACTEMRA not be initiated in patients with an absolute neutrophil count (ANC) below 2000 per mm3, platelet count below 100,000 per mm3, or who have ALT or AST above 1.5 times the upper limit of normal (ULN).

Laboratory monitoring—recommended due to potential consequences of treatment-related changes in neutrophils, platelets, lipids, and liver function tests.

Provider Name (Print) **Provider Signature** **Date**

Please include the following information when submitting a referral for Actemra:
*Results of a recent tuberculosis (TB) skin/lab testing
*Clinicals to support one or more of the following:
*Patient has moderately to severely active rheumatoid arthritis (RA) who has had an inadequate response to one or more disease modifying anti-rheumatic drugs (DMARDs)
*Patient has giant cell arteritis (GCA)
*Patient has active polyarticular juvenile idiopathic arthritis
*Patient has active systemic juvenile idiopathic arthritis