Palmetto Infusion Services

MRN:_____

Phone: 800-809-1265 DOB:_____

STANDARD ACTEMRA PLAN OF TREATMENT

(Re) Certification dates from: _____ to: _____

NOTE: Patient is ***ineligible*** to receive Tocilizumab if receiving antibiotic for active infectious process (due to the possibility of developing a super-infection related to its effect on the immune status), or if he/she has a suspected infection.

Patient Name _____ Weight: _____ Height: _____ Allergies: _____

Diagnosis: ☐ 714.0 Rheumatoid Arthritis ☐ 714.2 Other Rheumatoid Arthritis

My patient has had an inadequate response or failed treatment to:_____
(Indicate TNF therapy that patient has tried and failed)

Premedicate : ☐ None ***OR*** ☐ 30 minutes prior to infusion with 650 mg Acetaminophen PO and one of the following oral antihistamines: ☐ Diphenhydramine 50 mg ☐ Fexofenadine 60 mg ☐ Fexofenadine 180 mg ☐ Cetirizine 10 mg ☐ Loratadine 10 mg ***OR*** ☐ Premedicate with other _____

Obtain weight each visit. Vital signs every 30 minutes beginning with start of infusion and 30 minutes after completion for the first 3 doses. Instruct patient/caregiver on medications, signs/symptoms of adverse reaction. Assess patient for response to therapy.
If adverse drug reaction, implement the Standing Adverse Reaction Protocol.
Utilize existing central line for administration, or initiate a peripheral IV with each infusion, prn.
Normal Saline Flush 3-10 ml before infusion, after primary drug has infused, Infuse Normal Saline 20-50 ml to flush tubing/line, followed by Heparin 100 units/ml 1 – 5 ml per line type. Pump, tubings, and supplies needed to complete prescribed therapy.

Dose: to be infused over 1 hour or greater as tolerated every 4 weeks

☐ Tocilizumab (Actemra) **4 mg/kg** in NS IV
☐ Tocilizumab (Actemra) **8 mg/kg** in NS IV

Lab Orders: (Should be drawn prior to infusion)

CBC with diff and Platelets and LFT's: initially, at 2nd infusion, and then every 8 weeks with infusion
Cholesterol levels initially, at 2nd infusion, and then every 6 months
******* DO NOT INFUSE if ANC < 2000/mm on initiation of therapy, ***** HOLD dose if Liver enzymes >3-5 X ULN*******

Ongoing treatments:
If ANC >1000 Maintain dose
If ANC 500 to 1000: Interrupt Tocilizumab dosing. When ANC >1000 cells/mm3 resume Tocilizumab at 4 mg/kg and increase to 8 mg/kg as clinically appropriate
ANC <500 Discontinue Tocilizumab,
Platelet Counts 50,000 to 100,000: Interrupt Tocilizumab dosing. When platelet count is >100,000 cells/mm3 resume Tocilizumab at 4 mg/kg and increase to 8 mg/kg as clinically appropriate
<50,000 Discontinue Tocilizumab

Other: Pharmacist to perform clinical drug monitoring.

(No Stamped Signatures Please)

Physician's Signature: _____ _____ Date: _____
(Dispense as written) (Substitution permitted)

Print Physician Name: _____

PLEASE FAX DEMOGRAPHICS AND INSURANCE INFORMATION to 866-872-8920

Patient should have a negative PPD within 6 months, documented absence of active TB, as well as documented Hep B surface antigen.

Does the patient have a history of (circle each): TB SOB Cough Night Sweats Fever Weight Loss None
Has the patient had recent exposure to TB or been out of the country in the past month? ☐ Yes ☐ No
Does the patient have a family history of TB? ☐ Yes ☐ No Chest X-Ray: ☐ Yes ☐ No Results: _____
Has the patient had a PPD test? ☐ Yes ☐ No Date _____ Results _____ **Palmetto must have copy on file**
Any previous treatment for TB? ☐ Yes ☐ No
Has patient received ***TNF therapy in past 6 months?*** ☐ Yes ☐ No Therapy: _____ Last date Received:_____
Hep B surface antigen drawn: ☐ Yes ☐ No Please fax results with referral along with PPD results