

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