Palmetto INFUSION

MRN:_____

Phone: 1-800-809-1265 Fax: 1-866-872-8920

DOB:_____

STANDARD Actemra® (tocilizumab) PLAN OF TREATMENT for Pediatric – (over 2 years of age)

NOTE: Patient ***may be ineligible*** to receive tocilizumab if receiving antibiotics for active infectious process, antifungal therapy, active fever and/or suspected infection, new-onset or deterioration neurological changes, new-onset abdominal symptoms, and/or surgery.

1. Patient Name: _____Height (inches): _____Weight (lbs):_____

2. Allergies:_____

3. Diagnosis: * Please complete the 2nd and 3rd digits to complete the ICD-10 code for billing

☐ **M08.2**____ Juvenile Rheumatoid Arthritis with Systemic Onset ☐ **M08.3** Juvenile Rheumatoid Polyarthritis (seronegative)

☐ Other **ICD-10 Code**: _____**Diagnosis description:**_____

4. Pre-medications: ☐ None ***OR*** ***Administered 30 minutes prior to infusion as selected:***

a) Acetaminophen _____mgs PO or □ Liquid 160mg/5ml dose of ____mls as specified by referring MD
b) Diphenhydramine: _____mgs PO or _____mgs IV □ Liquid 12.5mg/5ml dose of ____mls as specified by referring MD
c) Pre-medicate with other: _____

Orders: Obtain weight each visit. **Vital signs with initial 3 treatments: at baseline, every 15 minutes for first hour, at completion, and 30 minutes post completion. Vital signs with subsequent infusions: at baseline, every 30 minutes until infusion completed, at completion, and then may discharge.** Instruct patient/caregiver on medications and signs/symptoms of adverse reaction. Assess patient for response to therapy. Utilize existing central line for administration or initiate a peripheral IV with each infusion as needed. Sodium Chloride 0.9% flush 3-10 ml before, after, and as needed during the infusion. Follow infusion with Pediatric Heparin 10 units/ml 1-5 ml or Heparin 100 units/ml 1 – 5 ml per line type or to peripheral IV as required for multiple day treatments. Pump, tubing, 0.22 micron filter, and supplies needed to complete prescribed therapy. Pharmacist to perform clinical drug monitoring. ***If adverse drug reaction occurs, utilize the ADVERSE DRUG REACTION GUIDELINES. Maximum dose of 800mgs.***

5. Dose: Actemra® (tocilizumab) IV over 1 hour or greater as tolerated.

Dosage for Polyarticular JIA: Infuse every 4 weeks (No < 28 days)	**Dosage for Systemic JIA: Infuse every 2 weeks (No < 14 days)**
☐ **Less than 30 kg weight – 10mg/kg in 50ml Sodium Chloride 0.9%**	☐ **Less than 30 kg weight – 12mg/kg in 50ml Sodium Chloride 0.9%**
☐ **30 kg or above weight – 8mg/kg in 100ml Sodium Chloride 0.9%**	☐ **30 kg or above weight – 8mg/kg in 100ml Sodium Chloride 0.9%**
Lab orders for Polyarticular JIA: **CBC with diff, platelets, ALT and AST prior to first dose, at 2nd infusion, and then every 8 weeks.** **Cholesterol prior to first dose, at 2nd infusion, and then every 6 months.**	**Lab orders for Systemic JIA:** **CBC with diff, platelets, ALT and AST prior to first dose, at 2nd infusion, and then every 4 weeks.** **Cholesterol prior to first dose, at 2nd infusion, and then every 6 months.**

Lab parameters for treatment: (Pharmacist to perform clinical lab monitoring)
**** If ANC <2000/mm³ on initiation of therapy, DO NOT INFUSE****
If ANC >1000 cells/mm³, maintain dose. If ANC is 500 to 1000 cells/mm³, interrupt tocilizumab dosing and notify referring MD. When ANC >1000 cells/mm³, resume Tocilizumab. If ANC < 500 cells/mm³, then discontinue tocilizumab and notify referring MD.
If Platelet count 50,000 to 100,000 cells/mm³, then interrupt tocilizumab dosing. When platelet count is > 100,000 cells/mm³, resume tocilizumab as clinically appropriate. If Platelet count is <50,000 cells/mm³, then discontinue tocilizumab and notify referring MD.
If Liver enzymes are > 3-5 x upper limit normal or ALT/AST are > 1.5x upper limit normal, then HOLD dose of tocilizumab.
If Cholesterol levels are elevated, notify referring MD for clinical evaluation and monitoring.

6. Physician's Signature: _____/ _____Date: _____

No Stamp Signatures (Dispense as written) (Substitution permitted)

Printed Physician's Name with Credentials: _____

7. Fax updated supporting clinical MD notes with each order renewal or change in orders

Infusion order forms available at www.palmettoinfusion.com

Revised 4/20/17

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MRN:_____

DOB:_____

Guidelines for Prescribing Actemra ® (tocilizumab) for Pediatric (over 2 years of age)

(Required documentation with all initial referrals)

Patient Name: _____ **Referral Date:**_____

☐ Include signed and completed **Plan of Treatment**. *(MD must complete sections 1-7)*
(Infusion order forms & Standard Adverse Reactions orders are available at www.palmettoinfusion.com under Agency/MD tab)

☐ Include patient demographic information and insurance information.
(Copy of insurance cards if available)

☐ **Supporting clinical MD notes to include any past tried and/or failed therapies, intolerance, outcomes or contraindications to conventional therapy. Include any lab results and/or tests to support diagnosis.**

- ACTEMRA® (tocilizumab) is indicated for dosing frequency for the treatment of Polyarticular Juvenile Idiopathic Arthritis (PJIA) every 4 weeks and Systemic Juvenile Idiopathic Arthritis (SJIA) every 2 weeks in patients 2 years of age and older. Treatment may be used alone or in combination with methotrexate.

☐ If patient is switching biological therapies, then MD must specify wash-out period prior to starting Actemra® as specified of _____ weeks. Last known biological therapy: _____ and last date received:_____. (Include copy of last ACTEMRA® infusion record if available and currently on therapy)

☐ Other as requested: _____
_____
_____

Pre-Screening: (**TB and Hepatitis screening results must be available prior to start of therapy and within last 12 months.**)

☐ **Required TB screening results: PPD or QuantiFERON Gold Test.**
(* If screening results are positive or indeterminate, then a negative CXR result is required.)

☐ **Required Hepatitis screening to include: Hepatitis B Surface Antigen results.**

☐ **Lab results within last 30-60 days: CBC with diff, Platelets, both AST and ALT, and Cholesterol levels.**
(It is recommended that tocilizumab not be initiated in patients with an ANC of less than 2000/mm^3, platelet count below 100,000/mm3, or who have ALT or AST greater than 1.5 x the upper limit of normal.)

** Warnings/Precautions: **Serious infections**: leading to hospitalization or death including tuberculosis (TB), bacterial, invasive fungal, viral, and other opportunistic infections have occurred in patients receiving ACTEMRA®. Pre-screening for TB prior to starting ACTEMRA. The safety and efficacy of ACTEMRA have not been studied in patients with hepatic impairment, including patients with positive HBV and HCV serology. Consider interrupting therapy with Actemra® if patients develop a new infection during treatment. Most patients who developed these infections were taking concomitant immunosuppressants such as methotrexate or corticosteroids. Actemra ® has not been studied in combination with other biologics. **Gastrointestinal (GI) perforation:** Events of gastrointestinal perforation have been reported in clinical trials, primarily as complications of diverticulitis in RA patients. Use ACTEMRA with caution in patients who may be at increased risk or history of diverticulitis/GI Bleed. Evaluate patients presenting with new onset abdominal symptoms for early identification of gastrointestinal perforation. ***Laboratory monitoring*** – recommended due to potential consequences of treatment-related changes in neutrophils, platelets, lipids, and liver function tests. Evaluation of immunizations should be completed prior to and live vaccines should not be given before or concurrently with Actemra ®. See full prescribing information

Palmetto Infusion Services will complete insurance verification and submit all required clinical documentation to the patient's insurance company for eligibility. Our office will notify you if any further information is required. We will review financial responsibility with the patient and refer them to any available Co-pay assistance as required. Thank you for the referral.

Please fax all information to 1-866-872-8920 or call 1-800-809-1265 for assistance.

Revised 4/20/17