Palmetto INFUSION®

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

| Referral Status: | | MRN: |
|---|---|---|
| ☐ New referral | ☐ Order change | ☐ Order Renewal |
| Patient preferred clinic: | | |

# Actemra® (tocilizumab) Pediatric – (over 2 years of age) Standard Plan of Treatment

## PATIENT DEMOGRAPHICS:

| | | | |
|---|---|---|---|
| Date of Referral: | | Patient's Phone: | |
| Patient Name: | | Address: | |
| Date of Birth: | | City, State, Zip: | |
| Height in inches: | Weight: LB or KG | Gender: | Allergies: ☐ See list ☐ NKDA |

## DIAGNOSIS: (PLEASE COMPLETE 2ND AND 3RD DIGITS TO COMPLETE ICD 10 FOR BILLING )

- ☐ M08.2 - Juvenile Rheumatoid Arthritis with Systemic Onset
- ☐ M08.3 - Juvenile Rheumatoid Polyarthritis (seronegative)
- ☐ _____ - Other:

## REQUESTED DOCUMENTATION:

| | |
|---|---|
| 1 | Insurance information |
| 2 | Most recent History & Physical |
| 3 | Full medication list / Tried and failed therapies |
| 4 | **REQUIRED:** TB screening for new start patients |
| 5 | HBV screening/labs as required by payor |
| 6 | Recent CBC with diff and LFTs |

## PREVIOUS ADMINISTRATION: HAS THIS PATIENT TAKEN THIS MEDICATION BEFORE?

| IF NO: | IF YES: |
|---|---|
| PLEASE STATE REQUIRED WASHOUT FROM PREVIOUS THERAPY: | LAST INFUSION DATE: |
| | NEXT INFUSION DATE: |
| | **IF ORDER CHANGE:** |
| | ☐ **Continue current order until insurance approved** |

## MEDICATION ORDERS:

**PREMEDICATION TO BE ADMINISTERED 30 MINUTES PRIOR TO ADMINISTRATION AS SELECTED**

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.

| IV | | | | | |
|---|---|---|---|---|---|
| | Diphenhydramine | ☐ 25mg | ☐ 50mg | | |
| | Methylprednisolone | ☐ 40mg | ☐ 125mg | ☐ Other: | |
| | Famotidine | ☐ 20mg | ☐ 40 mg | | |
| | Other: | ☐ | | | |

| PO | | | | | |
|---|---|---|---|---|---|
| | Acetaminophen | ☐ 325mg | ☐ 500mg | ☐ 160mg/5ml | mls |
| | Famotidine | ☐ 20mg | ☐ 40mg | | |
| | Diphenhydramine | ☐ 25mg | ☐ 50mg | ☐ 12.5mg/5ml: | mls |
| | Loratadine | ☐ 10mg | | | |
| | Other: | ☐ | | | |

### MEDICATION:

☑ Actemra® (tocilizumab) in 100ml NS given IV over 1 hour or greater as tolerated.

### DOSE: for Polyarticular JIA every 4 weeks (No < 28 days)

- ☐ Less than 30 kg weight – 10mg/kg in 50ml NS
- ☐ 30 kg or greater – 8mg/kg in 100ml NS

### DOSE: for Systemic JIA every 2 weeks (No < 14 days)

- ☐ Less than 30 kg weight – 12mg/kg in 50ml NS
- ☐ 30 kg or above weight – 8mg/kg in 100ml NS

### SPECIAL ORDERS:

☐ _____

### LAB ORDERS:

**CBC with diff, platelets, ALT and AST prior to first dose, at 2nd infusion, and then every 4 weeks.**

### LAB PARAMETERS: (Pharmacist to perform clinical lab monitoring)

On Initiation: ANC > 2000mm$^3$; AST/ALT < 1.5 x ULN

Maintenance: **If ANC** is 500 to 1000 cells/mm$^3$, hold dose and notify referring MD. When ANC >1000 cells/mm$^3$ therapy may be resumed. If ANC < 500 cells/mm$^3$, then discontinue and notify referring MD. **If Platelet count** 50,000 to 100,000 cells/mm$^3$, hold dose. When platelet count is > 100,000 cells/mm$^3$, therapy may be resumed. If Platelet count is <50,000 cells/mm$^3$, then discontinue and notify referring MD. **If AST/ALT** are > 3 5 x upper limit normal HOLD dose and notify referring MD

**ACTEMRA® doses exceeding 800 mg are not recommended**

**Prescriber confirms that the patient has been evaluated and screened for the presence of hepatitis B virus (HBV) prior to initiating treatment. Prescriber to monitor patient for symptoms of HBV and TB infection and reactivation as clinically appropriate.**

☑ Refills x 12 months unless noted otherwise here:

## LINE USE/CARE ORDERS:

- ☑ Start PIV/Access CVC
- ☑ Flush device per facility standard flushing procedure

## ADVERSE REACTION & ANAPHYLAXIS ORDERS:

Administer acute infusion and anaphylaxis medications per Palmetto Infusion standing adverse reaction orders, which can be found at our website or scan here.

## PRESCRIBER INFORMATION:

| | |
|---|---|
| PROVIDER NAME: | PHONE: |
| ADDRESS: | FAX: |
| CITY, STATE, ZIP: | NPI: |

| PRESCRIBER SIGNATURE: (No stamp signatures) | | DATE |
|---|---|---|
| | | |
| Dispense as written/Brand medically necessary | Substitution permitted | |