

Referral Status:	MRN:
<input type="checkbox"/> New referral	<input type="checkbox"/> Order change
<input type="checkbox"/> Order Renewal	
Patient preferred clinic:	

Actemra® (tocilizumab) Standard Plan of Treatment for Rheumatology

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:
<input type="checkbox"/> See list	<input type="checkbox"/> NKDA

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

M05.____ - Rheumatoid Arthritis with Rheumatoid factor	M31.6 - Other Giant Cell Arteritis
M06.____ - Rheumatoid Arthritis without Rheumatoid factor	M31.5 - Giant cell Arthritis with Polymyalgia Rheumatica
____ - 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
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	650mg	1000mg
	Famotidine	20mg	40mg		
	Diphenhydramine	25mg	50mg		
	Fexofenadine	60mg	180mg		
	Cetirizine	10mg			
	Loratadine	10mg			
	Other:				

MEDICATION:

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

DOSE: Rheumatoid Arthritis

4mg/kg in 100mL NS every 4 weeks
 8mg/kg in 100mL NS every 4 weeks

DOSE: Giant Cell Arthritis

6mg/kg in 100mL NS every 4 weeks

SPECIAL/LAB ORDERS:

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.

LAB ORDERS:

CBC with diff, platelets, ALT and AST prior to first dose, at 2nd infusion, and then every 12 weeks.

LAB PARAMETERS: (Pharmacist to perform clinical lab monitoring)

On Initiation: ANC > 2000mm³; AST/ALT < 1.5 x ULN
 Maintenance: If ANC is 500 to 1000 cells/mm³, hold dose and notify referring MD. When ANC > 1000 cells/mm³ therapy may be resumed. If ANC < 500 cells/mm³, then discontinue and notify referring MD. If Platelet count 50,000 to 100,000 cells/mm³, hold dose. When platelet count is > 100,000 cells/mm³, therapy may be resumed. If Platelet count is < 50,000 cells/mm³, then discontinue and notify referring MD. If AST/ALT are > 3 x upper limit normal HOLD dose and notify referring MD

ACTEMRA® doses exceeding 800 mg are not recommended.

Refills x 12 months unless noted otherwise here:

NURSING ORDERS:

- Start PIV/Access CVC
- Flush device per facility standard flushing procedure
- Provide nursing care per Palmetto Infusion Nursing Procedures and post procedure observation if indicated

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