TOCILIZUMAB (ACTEMRA®) PRESCRIBER ORDER FORM

Patient Name:				Date of Birth:	
Address:					
Patient Phone:	Height:	☐ inches ☐ cm	Weight:		☐ lbs. ☐ kg

Clinical Information

Primary Diagnosis Description:	ICD-10 Code:

Is this the first dose? ☐ YES – Date of first dose: __________________ ☐ NO – Date of next dose due: __________________________

TB Status:
- ☐ PPD (negative) – Date: _______________
- ☐ Last chest x-ray – Date: _______________
- ☐ QuantiFERON or T Spot Assay result and date: ____________
- ☐ Active TB
- ☐ Unknown
- ☐ Past positive TB infection, course taken: _________________

Tocilizumab (Actemra®) Prescription

Tocilizumab (Actemra®) refill as directed x 1 year
- ☐ Infuse _____ mg/kg IV over 60 minutes every 4 weeks – max 800 mg.
- ☐ Inject 162 mg SubQ once ☐ every week ***or*** ☐ every other week.

Tocilizumab-aazg (Tyenne®) (refill as directed x 1 year
- ☐ Infuse _____ mg/kg IV over 60 minutes every ☐ 2 or ☐ 4 weeks – max 800 mg.
- ☐ Inject 162 mg SubQ once ☐ every week ***or*** ☐ every other week.

Tocilizumab-bavi (Tofidence®) refill as directed x 1 year
- ☐ Infuse _____ mg/kg IV over 60 minutes every ☐ 2 or ☐ 4 weeks – max 800 mg.
- ☐ Other: ____

Ancillary Orders

Anaphylaxis Kit

Dosage:
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
- Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
- 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

Medication Orders
- ☐ Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may use own supply or patient may decline.
- ☐ Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may use own supply or patient may decline.
- ☐ Methylprednisolone sodium succinate 40 mg IV push 20 minutes prior to infusion.
- ☐ Other: ____

IV Flush Orders
- ☐ Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- ☐ Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr. if accessed or weekly to monthly if not accessed.

Lab Orders
- ☐ No labs ordered at this time.
- ☐ Other: ____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year. If infusing via Peripheral IV, skilled nurse to insert.

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.

Prescriber Signature: **Date:**

Prescriber Information

Prescriber Name:		Phone:	Fax:
Address:		NPI:	
City, State:	Zip:	Office Contact:	
Fax completed form, insurance information, and clinical documentation to:			

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