Tocilizumab (ACTEMRA)

6955 Foothill Blvd, Suite 67A, Oakland, CA, 94605
Phone: (510) 878-9528 | Fax: (510) 969-5840 | Email: referrals@totalinfusion.com

Name: ______________________________

DOB: ______________ Phone: ______________

Gender: ☐ Male ☐ Female

Allergies: ______________________________

DIAGNOSIS (ICD-10 code required):

☐ _______ Rheumatoid Arthritis (RA)

☐ _______ Other: _______________

PROVIDER REMINDERS:

- All orders with a ☑ will be placed unless otherwise noted
- Screen for viral hepatitis prior to use
- Ensure baseline PPD or quantiFERON-TB assay for latent TB
- Live vaccines should not be given concurrently or within 3 months of discontinuation of therapy
- Do not combine with tumor necrosis factor (TNF) agents or other biologic DMARDS
- CBC w/diff and ALT/AST prior to each treatment
- Lipid Panel at baseline, then 4 and 8 weeks after initiation of treatment and every 6 months thereafter

TREATMENT CRITERIA:

Hold Tocilizumab (ACTEMRA) if:

- Temperature **GREATER THAN** 100 degrees F
- Complains of symptoms of acute viral or bacterial illness
- Taking antibiotics for current infection
- *Initial dose only:* Unable to verify negative TB results
- ANC **LESS THAN** 2,000 (first dose) 1,000 (subsequent)
- Platelets **LESS THAN** 100,000 (first dose) 50,000 (subsequent)
- AST/ALT **GREATER THAN** 1.5 x ULN
- Live vaccines recieved within 30 days of treatment

Notify Provider if:

- Unable to verify lipid panel has been drawn as indicated above (Instruct patient to have labs drawn today and proceed with infusion)

Special Instruction(s):

Premedications

☐ **Acetaminophen (TYLENOL) 650mg PO**, Once, 30 minutes prior to Tocilizumab infusion.

☐ **Cetirizine (ZYRTEC) 10mg PO**, Once, 30 minutes prior to Tocilizumab infusion.

☐ **Hydrocortisone Sodium Succinate (SOLU-CORTEF) 50mg IVP (NOT ROUTINE; ONLY IF BREAKTHROUGH REACTION)** Once PRN, 30 minutes prior to Tocilizumab infusion in addition to Acetaminophen and Cetirizine if patient experiences symptoms with Acetaminophen and Cetirizine alone.

☐ ______________________________

Medications

Patient Weight ______kg **(REQUIRED)**

Infuse **Tocilizumab (ACTEMRA)** Intravenously over 60 minutes

Dose/Frequency:

☐ 4mg/kg every 4 weeks for _____ treatments, then 8mg/kg every 4 weeks

☐ 4mg/kg every 4 weeks

☐ 8mg/kg every 4 weeks

☐ ______________________________

☐ **IV LINE CARE** per Nursing Policy

☐ **INFUSION REACTION MEDICATIONS** per Standardized Procedures

☐ **TREATMENT ORDER WEIGHT** will be utilized for the duration of the order. Patient will be weighed prior to every treatment. Prescriber will be notified of weight change greater than 10% from baseline weight.

Provider Signature ______________ Date ______________ Email ______________

Printed Name ______________ Phone ______________ Fax ______________

Office Contact ______________ Phone ______________ Email ______________