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| ADULT AMBULATORY INFUSION ORDER  **Tocilizumab (ACTEMRA)** |   **NAME:** **BIRTHDATE:** *Affix Patient Identification Label Here* |
| **ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (**  **) TO BE ACTIVE.**  |

**Date: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_**

\***Please fax a copy of the** □Demographics □ Insurance Information □ Current Lab Results

**following patient information**: □ H & P Relevant to Diagnosis □ Last infusion note □ Current Medications

Provider Information

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed Provider’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Information

Weight: \_\_\_\_\_\_\_\_\_\_\_\_ lbs/kg Height: \_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_/\_\_\_\_\_/\_\_\_\_\_\_

ICD-10: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_\_

 Office Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TB Test Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_ □ Copy Attached

Hep B Date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Result: \_\_\_\_\_\_\_\_\_\_\_\_ □ Copy Attached

Pre-medications:

Diphenhydramine: □ PO □ IV □ 25 mg □ 50mg

Acetaminophen: □ PO □ 650 mg □ 1000 mg

Solu-Medrol: □ IV □ 40 mg □ 125 mg

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No Pre-Medications

Wait Time after Pre Medications:

 □ 20 minutes □ 30 minutes □ Other: \_\_\_\_\_\_\_\_\_\_\_\_ □ No wait time

MC2833 (10/24)

Labs:

□ CBC w/diff □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ CMP □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ CRP □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ ESR □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other: \_\_\_\_\_\_\_\_\_ □ EVERY infusion □ every OTHER infusion □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ No labs needed

 **Actemra (tocilizumab) IV Dosage**

Frequency:□ Initial dose of 4 mg/kg every 4 weeks, then 8 mg/kg every 4 weeks.

□ 4 mg/kg every 4 weeks

□ 8 mg/kg every 4 weeks

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **⦁ Doses exceeding 800 mg per infusion are not recommended in RA/CRS diagnosis**

 **⦁ Doses exceeding 600 mg per infusion are not recommended in GCA diagnosis**

**Weight based doses will be rounded to the nearest vial (100 mg per vial)**

Dilute in 100 mL 0.9% sodium chloride. Infuse Actemra over 1 hour and protect from light.

Next dose due: \_\_\_\_ /\_\_\_ /\_\_\_\_