BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

ACTEMRA (TOCILIZUMAB) ORDERS

PATIENT INFORMATION

Name: ______________________ DOB: __________ Height: ________ Weight: ________

Address: ______________________ Phone: ______________ Allergies: ____________

City, State, Zip: ______________________ Email: ______________

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: ______________ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD-10 CODE

☐ Rheumatoid Arthritis ICD-10 Code: __________

☐ Systemic Juvenile Idiopathic Arthritis (SJIA) ICD-10 Code: __________

☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA) ICD-10 Code: __________

☐ Other: ______________________ ICD-10 Code: __________

REQUIRED DOCUMENTATION

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ TB Test Results

☐ H&P and Clinical/Progress notes supporting primary diagnosis

☐ Labs and Tests supporting primary diagnosis

List Tried & Failed Therapies, including duration of treatment:

1)

2)

3)

MEDICATION ORDERS

☐ Actrema 4mg/kg IV over 60 minutes every 4 weeks

☐ Actemra 8mg/kg IV over 60 minutes every 4 weeks

Note that doses >800mg for rheumatoid arthritis are not recommended.

☐ Actemra 162mg SubQ every week

☐ Actemra 162mg SubQ every 2 weeks

☐ Actemra 162mg SubQ every ____ weeks

** Dose may be rounded to nearest vial size within +/-10%. TO PROHIBIT dose rounding check here ☐

Refills: ☐ X 6 months ☐ X 1 Year ☐ Other: __________

☐ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

☐ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

☐ RN to flush and lock VAD/CVAD per company protocol

Other: ______________________

PREMEDICATION ORDERS

☐ Acetaminophen 650mg PO prior to infusion

☐ Diphenhydramine 25mg PO prior to infusion

☐ Other: ______________________

☐ Other: ______________________

EMERGENCY MEDICATIONS

☐ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: ______________________ NPI Number: __________

Office Phone: ______________ Office Fax: ______________

Prescriber Signature: ______________________ Date: __________

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