Fax: 832-895-4040
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adaptIV infusion

Actemra (Tocilizumab)

Provider Order Form rev. 4/10/2022

PATIENT INFORMATION

Referral Status *(check one):* ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____

NKDA ☐ Allergies: _____ Weight _____ *Please specify:* ☐ lbs ☐ kg Height: _____

Patient Status *(check one):* ☐ New to Therapy ☐ Continuing Therapy | Last Treatment Date: _____ Next Due Date: _____

ICD-10 code (required): _____ ICD-10 description: _____

REQUIRED: Demographics & Most Recent: H&P, clinical notes, & medication list. Supporting clinical notes to include any past tried and/or failed therapies, intolerance, outcomes, or contraindications to conventional therapy.

PRESCRIPTION

NURSING

☐ TB status & date (list results here & attach clinicals)

_____

☐ Provide nursing care per AdaptIV Infusion Nursing Procedures, including reaction management and post-procedure observation

LABORATORY ORDERS

☐ CBC ☐ at each dose ☐ every _____
☐ CMP ☐ at each dose ☐ every _____
☐ CRP ☐ at each dose ☐ every _____
☐ Other: _____

PRE-MEDICATION ORDERS

☐ acetaminophen (Tylenol) ☐ 500mg | ☐ 650mg | ☐ 1000mg PO
☐ cetirizine (Zyrtec) 10mg PO
☐ loratadine (Claritin) 10mg PO
☐ diphenhydramine (Benadryl) ☐ 25mg | ☐ 50mg | ☐ PO | ☐ IV
☐ methylprednisolone (Solu-Medrol) ☐ 40mg | ☐ 125mg IV
☐ hydrocortisone (Solu-Cortef) ☐ 100mg IV
☐ Other: _____

Dose: _____ Route: _____
Frequency: _____

THERAPY ADMINISTRATION

☐ **Tocilizumab** (Actemra) in 100ml 0.9% sodium chloride for patient weight >30kg or 50ml 0.9% sodium chloride for patient weight <30kg, intravenous infusion over one hour

- Dose: ☐ 4mg/kg / ☐ 8mg/kg / ☐ 10mg/kg / ☐ 12mg/kg
  ☐ round up to nearest whole vial
  ☐ give exact dose
- Frequency: ☐ every 2 weeks / ☐ every 4 weeks / ☐ other:
  _____
- Route: ☐ intravenous
- Infuse over 1 hour

☐ Flush with 0.9% sodium chloride at infusion completion

☐ **Tocilizumab** (Actemra) injection

- Dose: ☐ 162mg / ☐ _____ mg
- Frequency: ☐ weekly / ☐ every 2 weeks / ☐ every 3 weeks / ☐ other: _____
- Route: ☐ subcutaneous

☐ Patient is required to stay for 30-minute observation
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ other: _____
(if not indicated the order will expire one year from date signed)

*Perform test for latent TB; if positive, start treatment for TB prior to starting ACTEMRA. Monitor all patients for active TB during treatment, even if initial latent TB test is negative.

It is recommended that ACTEMRA not be initiated in patients with an absolute neutrophil count (ANC) below 2000 per mm3, platelet count below 100,000 per mm3, or who have ALT or AST above 1.5 times the upper limit of normal (ULN).

Laboratory monitoring—recommended due to potential consequences of treatment-related changes in neutrophils, platelets, lipids, and liver function tests.

SPECIAL INSTRUCTIONS

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____

Ordering Provider: _____ Provider NPI: _____

Referring Practice Name: _____ Phone: _____ Fax: _____

Practice Address: _____ City: _____ State: _____ Zip Code: _____

_____ _____ _____
Provider Name (Print) *Provider Signature* *Date*

REQUIRED: PLEASE INCLUDE ALL REQUIRED LABS AND A COPY OF PATIENT'S INSURANCE CARD – FRONT AND BACK