

Tocilizumab (Actemra)



Provider Order Form rev. 10/12/2022

PATIENT INFORMATION

Referral Status: New Referral Updated Order Order Renewal

Date: _____ Patient Name: _____ DOB: _____
ICD-10 code (required): _____ ICD-10 description: _____
 NKDA Allergies: _____ Weight (lbs/kg): _____ Height: _____
Patient Status: New to Therapy Continuing Therapy Last Treatment Date: _____ Next Due Date: _____

PROVIDER INFORMATION

Referral Coordinator Name: _____ Referral Coordinator Email: _____
Ordering Provider: _____ Provider NPI: _____
Referring Practice Name: _____ Phone: _____ Fax: _____
Practice Address: _____ City: _____ State: _____ Zip Code: _____

NURSING

- TB status & date (list results here & attach clinicals)
- Provide nursing care per IVX Nursing Procedures, including reaction management and post-procedure observation
NOTE: IVX Adverse Reaction Management Protocol available for review at www.ivxhealth.com/forms (version 09.07.2021)

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 / _____mg/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 / _____
(if not indicated order will expire one year from date signed)

SPECIAL INSTRUCTIONS

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.

Provider Name (Print) _____ Provider Signature _____ Date _____

FAX NUMBERS

- | | | | | |
|---|---|---|---|---|
| <input type="checkbox"/> BAY AREA: 844-889-0275 | <input type="checkbox"/> CONNECTICUT: 860-955-1532 | <input type="checkbox"/> HARRISBURG: 844-859-4235 | <input type="checkbox"/> PALM BEACH: 561-768-9044 | <input type="checkbox"/> TAMPA: 844-946-0849 |
| <input type="checkbox"/> CHARLOTTE: 336-663-0143 | <input type="checkbox"/> CHICAGO: 312-253-7244 | <input type="checkbox"/> INDIANAPOLIS: 844-983-2028 | <input type="checkbox"/> PHILADELPHIA: 844-820-9641 | <input type="checkbox"/> WEST TN/AR: 888-615-1445 |
| <input type="checkbox"/> CINCINNATI: 844-946-0868 | <input type="checkbox"/> COLUMBUS: 844-627-2675 | <input type="checkbox"/> JACKSONVILLE: 904-212-2338 | <input type="checkbox"/> RALEIGH: 919-287-2551 | <input type="checkbox"/> MIDDLE TN: 888-615-1445 |
| | <input type="checkbox"/> DAYTONA: 386-259-6096 | <input type="checkbox"/> KANSAS CITY: 844-900-1292 | <input type="checkbox"/> SARASOTA: 941-870-6550 | <input type="checkbox"/> EAST TN: 615-425-7427 |
| | <input type="checkbox"/> FT. LAUDERDALE: 754-946-2052 | <input type="checkbox"/> ORLANDO: 844-946-0867 | <input type="checkbox"/> SOUTHWEST FL: 813-283-9144 | |