

ACTEMRA® (tocilizumab)

Patient Information

Full Name: _____ Weight: _____ lbs kg Height: _____
 DOB: _____ Allergies: NKDA _____
 Phone Number: _____
 Patient Status: New to therapy Continuing therapy Last Treatment Date: _____ Next Treatment Date: _____

Required Documentation

- Patient Demographics and Insurance Card Medication List TB Test
 Clinical/Progress Notes Supporting Dx Hep B Status Results CBC with diff, LFTS, Lipid Panel



Primary Diagnosis

-  ICD-10 Code (required): _____
 Rheumatoid arthritis Systemic sclerosis-associated interstitial lung disease
 Giant cell arthritis Cytokine release syndrome
 Juvenile rheumatoid arthritis Other: _____

Pre-Medication

- Per violet health protocol: No recommended standard pre-medications for Tocilizumab
 Acetaminophen (Tylenol) PO 500mg 650mg 1000mg
 Diphenhydramine (Benadryl) 25mg 50mg PO IV
 Methylprednisolone (Solu-Medrol) IV 40mg 125mg
 Cetirizine (Zyrtec) 10 mg PO
 Other: _____

Therapy Administration

- Tocilizumab 4mg/kg IV every 4 weeks
 Tocilizumab 6mg/kg IV every 4 weeks
 Tocilizumab 8mg/kg IV every 4 weeks
 Other: _____
 **Max. dose of 800mg**
Refills:
 x 1 year Other: _____
 Order valid for one year unless otherwise stated
- RN to flush and lock VAD/CVAD per violet health protocol (see violetinfusions.com/protocol for policy)
 Administer acute infusion and anaphylaxis medications per violet health protocol (see violetinfusions.com/protocol for policy)
 RN to manage VAD per company protocol and administer ordered therapy per manufacturer guidelines.
 RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration.
 Other: Please fax alternative reaction orders, flush orders, or nursing administration orders if checking this box

Lab Orders

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

Provider Information

Provider Name: _____ Office Contact Person: _____
 Referring Practice Name: _____ Phone Number: _____
 Referring Practice Address: _____ Fax Number: _____
 City, State, Zip: _____ Email: _____
 Provider NPI: _____
 Provider Signature: _____ Date: _____