

**TOCILIZUMAB (ACTEMRA®) PRESCRIBER ORDER FORM**

<b>Patient Name:</b>	<b>Date of Birth:</b>	<b>Gender:</b>
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<b>Address:</b>
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<b>Patient Phone:</b>	<b>Height:</b>	<input type="checkbox"/> inches <input type="checkbox"/> cm	<b>Weight:</b>	<input type="checkbox"/> lbs. <input type="checkbox"/> kg
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**Clinical Information**

<b>Primary Diagnosis Description:</b>	<b>ICD-10 Code:</b>
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**Is this the first dose?**     YES – Date of first dose: \_\_\_\_\_     NO – Date of last dose: \_\_\_\_\_

<b>TB Status:</b>	<input type="checkbox"/> PPD (negative) – Date: _____	<input type="checkbox"/> Active TB
	<input type="checkbox"/> Last chest x-ray – Date: _____	<input type="checkbox"/> Unknown
	<input type="checkbox"/> QuantiFERON or T Spot Assay result and date: _____	<input type="checkbox"/> Past positive TB infection, course taken: _____

**Tocilizumab (Actemra®) Prescription****Tocilizumab (Actemra®) refill as directed x 1 year**

- Infuse \_\_\_\_ mg/kg IV over 60 minutes every 4 weeks – max 800 mg.
- Inject 162 mg SubQ once  every week or  every other week.

**Tocilizumab-aazg (Tyenne®) ( refill as directed x 1 year**

- Infuse \_\_\_\_ mg/kg IV over 60 minutes every  2 or  4 weeks – max 800 mg.
- Inject 162 mg SubQ once  every week or  every other week.

**Tocilizumab-bavi (Tofidence®) refill as directed x 1 year**

- Infuse \_\_\_\_ mg/kg IV over 60 minutes every  2 or  4 weeks – max 800 mg.
- Other: \_\_\_\_\_

**Ancillary Orders****Anaphylaxis Kit**

- Dosage:**
- Epinephrine 0.3 mg (> 30 kg), 0.15 mg (15 to 30 kg), or 0.01 mg/kg (< 15 kg) SUBQ or IM x 1; repeat x 1 in 5 to 15 min PRN.
  - Diphenhydramine 25 mg (> 30 kg) or 1.25 mg/kg (≤ 30 kg) IV or IM; repeat x 1 in 15 min PRN no improvement.
  - 0.9% Sodium Chloride 500 mL (> 30 kg) or 250 mL (≤ 30 kg) IV at KVO rate PRN anaphylaxis.

**Medication Orders**

- Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may use own supply or patient may decline.
- Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may use own supply or patient may decline.
- Methylprednisolone sodium succinate 40 mg IV push 20 minutes prior to infusion.
- Other: \_\_\_\_\_

**IV Flush Orders**

- Peripheral: 0.9% Sodium Chloride 2 to 3 mL pre-/post-use.
- Implanted Port: 0.9% Sodium Chloride 5 to 10 mL pre-/post-use and 10 to 20 mL pre-/post-lab draw. Heparin (100 unit/mL) 3 to 5 mL post-use. For maintenance, heparin (100 unit/mL) 3 to 5 mL every 24 hr. if accessed or weekly to monthly if not accessed.

**Lab Orders**

- No labs ordered at this time.
- Other: \_\_\_\_\_

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year. If infusing via Peripheral IV, skilled nurse to insert.

If patient is seen within a provider led infusion clinic, Option Care Health's infusion reaction management policy, skilled nursing plan of treatment, and IV flush administration will be followed per provider oversight. No individual anaphylaxis kit will be dispensed.

*I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.*

<b>Prescriber Signature:</b>	<b>Date:</b>
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**Prescriber Information**

<b>Prescriber Name:</b>	<b>Phone:</b>	<b>Fax:</b>
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<b>Address:</b>	<b>NPI:</b>
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<b>City, State:</b>	<b>Zip:</b>	<b>Office Contact:</b>
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**Fax completed form, insurance information, and clinical documentation to: 713-983-4647**

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