

Tocilizumab (Actemra®)

Along with this order form, please include the following: Demographics, Insurance Information, Lab Results, Current Medications, and Recent Visit Notes. ArrIVE Infusion will obtain any necessary medication authorizations for patients receiving infusion therapies.

Order Date: ____/____/____

Referral Status: ☐ New Referral ☐ Dose or Frequency Change ☐ Renewal

Patient Name: _____ Patient Address: _____ Patient Phone Number: _____ Date of Birth: ____/____/____ Weight: ____ kg Height: ____ cm Allergies: _____	Primary Insurance: _____ Member ID: _____ Secondary Insurance: _____ Member ID: _____												
<p style="text-align: center;">Diagnosis</p> <input type="checkbox"/> Rheumatoid arthritis with rheumatoid factor, unspecified (M05.9) <input type="checkbox"/> Rheumatoid arthritis without rheumatoid factor, other specified site (M06.0A) <input type="checkbox"/> Rheumatoid arthritis, unspecified (M06.9) <input type="checkbox"/> Juvenile rheumatoid arthritis with systemic onset, other specified site (M08.2A) <input type="checkbox"/> Juvenile rheumatoid polyarthritis (seronegative) (M08.3) <input type="checkbox"/> Giant cell arthritis with polymyalgia rheumatica (M31.5) <input type="checkbox"/> Other giant cell arthritis (M31.6) <input type="checkbox"/> Systemic sclerosis with lung involvement (M34.81) <input type="checkbox"/> Other Diagnosis Code (ICD-10): _____ <input type="checkbox"/> Other Indication: _____ Target start date: _____	<table style="width: 100%;"> <tr> <th style="text-align: left; width: 50%;">Labs</th> <th style="text-align: left; width: 50%;">Frequency</th> </tr> <tr> <td><input type="checkbox"/> LFTs</td> <td><input type="checkbox"/> Every infusion</td> </tr> <tr> <td><input type="checkbox"/> CBC w/ diff</td> <td><input type="checkbox"/> Other: _____</td> </tr> <tr> <td><input type="checkbox"/> CBC w/o diff</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Lipid panel</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other: _____</td> <td></td> </tr> </table>	Labs	Frequency	<input type="checkbox"/> LFTs	<input type="checkbox"/> Every infusion	<input type="checkbox"/> CBC w/ diff	<input type="checkbox"/> Other: _____	<input type="checkbox"/> CBC w/o diff		<input type="checkbox"/> Lipid panel		<input type="checkbox"/> Other: _____	
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Previously tried and failed therapies (include dates): _____													
Tocilizumab (Actemra®) in 100 mL of 0.9% sodium chloride													
Nursing note: Allow the fully diluted solution to reach room temperature prior to infusion. Protect from light.													
<p style="text-align: center;">Dose</p> <input type="checkbox"/> 4 mg/kg <input type="checkbox"/> 6 mg/kg <input type="checkbox"/> 8 mg/kg <input type="checkbox"/> ____ mg/kg <input type="checkbox"/> ____ mg	<p style="text-align: center;">Frequency</p> <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> Every ____ weeks Date of last infusion: ____/____/____												

Pre-Medications and Pre-Protocol (ordered at physician discretion)	<input type="checkbox"/> Acetaminophen 650 mg PO once <input type="checkbox"/> Loratadine 10 mg PO once <input type="checkbox"/> Diphenhydramine once <input type="checkbox"/> 25 mg <input type="checkbox"/> 50 mg <input type="checkbox"/> PO <input type="checkbox"/> IV <input type="checkbox"/> Famotidine 20 mg IV once <input type="checkbox"/> Hydrocortisone 100 mg IV once <input type="checkbox"/> Methylprednisolone 125 mg IVP once <input type="checkbox"/> Other: _____	Hydration <input type="checkbox"/> LR <input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> Other _____ _____ mL at _____ mL/hr <input type="checkbox"/> Before <input type="checkbox"/> During <input type="checkbox"/> Following
Flushing Protocol (pre and post medication)	<input type="checkbox"/> Sodium Chloride 0.9% <input type="checkbox"/> 5 mL <input type="checkbox"/> 10 mL as needed for line care	<input type="checkbox"/> Heparin _____ Units/mL _____ mL as needed for line care
Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary	<ul style="list-style-type: none"> • Sodium chloride 0.9% bolus 500 mL once as needed for hypotensive management (SBP <90mmHg) • Acetaminophen 650 mg once as needed for temperature GREATER than 38 C (100.4 F), headaches, generalized pain, back pain, abdominal cramping • Albuterol 2.5 mg /3 mL (0.083%) nebulizer solution 2.5 mg, nebulize every 10 min PRN, hypoxemia, bronchospasm, wheezing, dyspnea, for 2 doses • Albuterol HFA inhaler 2 puffs q4hs as needed for hypoxemia, bronchospasm, wheezing, dyspnea • Epinephrine injection 0.3 mg IM every 15 minutes as needed for SBP less than 90mmHg, mild to moderate anaphylaxis for 3 doses • Famotidine injection 20 mg IV over 2 minutes once as needed for severe hypersensitivity/infusion reaction including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Diphenhydramine injection 25 mg IV over 1 minute once as needed, moderate hypersensitivity/infusion reaction (grade 2) including temperature greater than 100.5, rigors, localized rash/hives, vomiting, nausea, pruritis, flushing, dizziness, back pain, abdominal cramping, uneasiness, agitation, feeling of impending doom • Diphenhydramine injection 50 mg IV over 1 minute once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure • Hydrocortisone sodium succinate injection 100 mg IV once as needed for severe hypersensitivity/infusion reaction (grade 3), including systolic BP 80-90 mmHg, bradycardia or tachycardia, hypoxemia, dyspnea, cognitive changes, generalized rash, chest pain/pressure 	
<div> <div> Provider Name: _____ </div> <div> Provider Signature: _____ </div> </div> <div> <div> Attending Physician Name: _____ </div> <div> Provider NPI: _____ </div> </div> <div> <div> Office Phone Number: _____ </div> <div> Office Fax Number: _____ </div> </div> <p><i>(If ordering provider is an advanced practice practitioner)</i> <i>Note: This order is valid for 12 months from date of physician signature.</i></p>		