

An Outpatient Department of Trinity Health Oakland 9406 Village Place Blvd, Brighton, MI 48116

Phone: 810-844-7373 Fax: 810-844-7366

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:	Primary Insurance:	
Patient Address:	Member ID:	
Patient Phone Number:	Secondary Insurance:	
Date of Birth:/	Member ID:	
Weight:kg Height:cm		
Allergies:		
Diagnosis	Labs Frequency	
☐ Rheumatoid arthritis with rheumatoid factor, unspecified	□ LFTs	
(M05.9)	☐ CBC w/ diff ☐ Every infusion	
☐ Rheumatoid arthritis without rheumatoid factor, other specifie	ed CBC w/o diff Other:	
site (M06.0A)	☐ Lipid panel	
☐ Rheumatoid arthritis, unspecified (M06.9)	☐ Other:	
\square Juvenile rheumatoid arthritis with systemic onset, other specified site (M08.2A)		
☐ Juvenile rheumatoid polyarthritis (seronegative) (M08.3)		
☐ Giant cell arthritis with polymyalgia rheumatica (M31.5)		
☐ Other giant cell arthritis (M31.6)		
☐ Systemic sclerosis with lung involvement (M34.81)		
☐ Other Diagnosis Code (ICD-10):		
☐ Other Indication:		
Target start date:		
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.		
Dose	Frequency	
□ 4 mg/kg	riequency	
☐ 6 mg/kg	☐ Every 4 weeks	
□ 8 mg/kg	☐ Every weeks	
□ mg/kg		
mg	Date of last infusion:/	



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LR Sodium Chloride 0.9% Sodium Chloride	Pre-Medications	☐ Acetaminophen 650 mg PO once	Hydration	
Opiphenhydramine once	and Pre-Protocol	☐ Loratadine 10 mg PO once	□ LR	
Physician discretion	(ordered at		☐ Sodium Chloride 0.9%	
PO IV	physician discretion)	□25 mg □50 mg	☐ Other	
Hydrocortisone 100 mg IV once Before During Following		□ PO □IV		
Hydrocortisone 100 mg IV once Before During Following		☐ Famotidine 20 mg IV once	mL atmL/hr	
Methylprednisolone 125 mg IVP once Other:		☐ Hydrocortisone 100 mg IV once	\square Before \square During \square Following	
Other: Sodium Chloride 0.9% 5 mL 10 mL Heparin 100 Units/L 5 mL 10 mL		_		
Sodium Chloride 0.9% 5 mL 10 mL Heparin 100 Units/L 5 mL 10 mL				
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Hypersensitivity Panel Together Care Hypersensitivity Panel will be ordered to provide emergency supportive care medication therapy as necessary Beneralized 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 - Famotifile injection 120 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 for severe 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 Provider Name: Provider Name: Provider Name: Office Phone Number: Office Phone Number: Office Fax Number: Office Fax Number:	_	☐ Sodium Chloride 0.9% ☐ 5 mL ☐ 10 mL	Heparin 100 Units/L □ 5 mL □ 10 mL	
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