Tocilizumab (Actemra)
ORDER FORM

REDINGTON-FAIRVIEW GENERAL HOSPITAL
(207) 474-5121 / WWW.RFGH.NET
Skowhegan, Maine

REQUIRED DOCUMENTATION attached:

- ❑ H&P completed within last year.
- ❑ Documentation supporting diagnosis and prior therapies for diagnosis.
- ❑ Documentation of tuberculosis (TB) testing – PPD or IGRA testing. Date of negative test:_____
- ❑ Patient is brought up to date with all immunizations before starting therapy.
- ❑ List of current medications and allergies.

Diagnosis: Patient weight _____ **kgs** Height _____ **inches**

☐ **Giant cell arteritis**
☐ **Kidney transplant, pretransplant desensitization**
☐ **Kidney transplant, antibody-mediated rejection**
☐ **Neuromyelitis optica**
☐ **Rheumatoid arthritis**

ORDERS

1. PPD or IGRA before start of therapy if none in past 12 months. Notify provider of positive results.
2. CBC with differential prior to therapy, 4 to 8 weeks after therapy and every 3 months
3. ALT/AST, alkaline phosphatase, and total bilirubin prior to therapy, every 4 to 8 weeks after therapy for the first 6 months and every 3 months thereafter
4. Lipid panel prior to therapy and 4 to 8 weeks after start of therapy.
5. Pregnancy test if between 14 and 50 years old with gestational potential.
6. Assess patient prior to each treatment for signs of infection, demyelinating disorders, new onset abdominal symptoms, or recent vaccinations.
   Hold treatment and notify provider if symptoms of uncontrolled serious infections or live vaccines administered within 4 weeks of starting therapy.
7. Provide FDA medication guide prior to first dose.
8. **TREATMENT: Tocilizumab* in NS 100 mL over 60 minutes** *Biosimilar per insurer and/or pharmacy
   (withdraw equal volume of NS to the volume of Tocilizumab required for dose)
   Dosr: ☐ 4 mg/kg ☐ 6 mg/kg ☐ 8 mg/kg **Frequency:** ☐ Every 4 weeks
   Maximum dose: 800 mg or _____ ☐ Every ____ weeks
9. Anaphylaxis kit in unit and initiate per anaphylaxis policy if signs and symptoms of allergic reactions.
10. Vital signs pre and post infusion. Patient may be discharged if post-infusion vital signs are stable.
11. Educate patient about signs and symptoms of severe infections, CNS demyelinating disorders, and new onset abdominal symptoms.

REQUIRED Prior Authorization Number: _____ [ ] pending [ ] Complete [ ] not needed*
*If not needed is chosen, date, time and name of person at health insurer who authorized.

Date:_____ Time:_____ Name:_____

Checklist for non-RFGH credentialed providers:
[ ] Provider to provider communication is required. If the patient has a Primary Care Provider at RFGH, please contact that PCP. Otherwise, **call (207) 474-5121** and ask to speak to hospitalist. Contacted provider: _____
[ ] Problem list & medication list attached to orders.

FAX completed order to Oncology at 207-858-2131

Provider signature _____Date_____time_____

If not RFGH credentialed: Printed name_____ Phone # _____

RFGH Co-signature _____ Date_____ time_____

Printed name_____
RFGH Copies to: IVT, Pharmacy resources
Prep: 8/24

Label or
Patient name_____

Date of birth_____

Patient phone number_____