HONORHEALTH

TOCILIZUMAB
(Actemra)
Order Form

Outpatient Infusion

Patient Name	
DOB	
Address	
Phone	

Order Status	☐ New Order	☐ Renewal	☐ Dose or Frequency Change
Allergies:			**Weight:** **Height:**
Diagnosis	☐ Rheumatoid arthritis ☐ Systemic sclerosis associated interstitial lung disease	☐ Cytokine release syndrome ☐ Giant cell arteritis ☐ Other:	**Diagnosis Code:**

Required Information	Negative Quantiferon TB, T-spot or chest x-ray (no active disease)	Date:
	Diagnostic Hepatitis B panel	Date:
	Coccidioides Screen/Panel	Date:
	CBC and CMP	Date:

Required Documentation

- H&P or progress note supporting diagnosis and medication history
- RA: Positive RF or anti-CCP or RF, Anti-CCP and CRP and/or ESR and inadequate response to methotrexate or another convention synthetic drug or inadequate response to NSAIDs and/or intra-articular glucocorticoids
- Giant cell arteritis: Temporal artery biopsy or cross-sectional imaging or acute-phase reactant elevation and/or high CRP
- SSc-ILD: HRCT study of chest
- Cytokine release syndrome: CAR T cell-induced CRS or refractory CRS related to blinatumomab therapy
- Recent labs (as above) and/or diagnostic test results

Labs	☐ Hepatic Function panel every 3 months	☐ Other:

Pre-Medications

☐ Diphenhydramine ○ PO ○ IV ○ 25 mg ○ 50 mg

☐ Acetaminophen ○ 325 mg ○ 650 mg

☐ Other:

Actemra (tocilizumab) IV Medication Order

☐ Actemra (tocilizumab) IV 4 mg/kg every _____ weeks
☐ Actemra (tocilizumab) IV 6 mg/kg every _____ weeks
☐ Actemra (tocilizumab) IV 8 mg/kg every _____ weeks
☐ Other:

Infusion Reaction Medications

Hypersensitivity Reaction Protocol will be utilized unless otherwise specified

Provider (print name):	Date:
Provider Signature:	NPI:
Office Phone:	Office Fax: