Tocilizumab (Actemra)

Provider Order Form rev. 11/23/2021

AleraCare
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PATIENT INFORMATION

Patient Name: DOB:

☐ NKDA Allergies: Weight lbs/kg:

Patient Status: ☐ New to Therapy ☐ Continuing Therapy Next Due Date (if applicable):

PROVIDER INFORMATION

Referral Coordinator Name: Referral Coordinator Email:

Ordering Provider: Provider NPI:

Referring Practice Name: Phone: Fax:

Practice Address: City: State: Zip Code:

LABORATORY ORDERS

☐ CBC
☐ CMP
☐ CRP
☐ Other: _____

ICD-10 Code

☐ M06.9 Rheumatoid arthritis
☐ M31.6 Giant Cell arteritis
☐ M34. 81 Systemic sclerosis associated interstitial lung disease
☐ M08. 40 Polyarticular juvenile idiopathic arthritis
☐ D89.83 Cytokine release syndrome
☐ Other: _____

SPECIAL INSTRUCTIONS

MEDICATION ORDER

☐ **Tocilizumab** (Actemra) in 100ml 0.9% sodium chloride for patient weight >30kg or 50ml 0.9% sodium chloride for patient weight <30kg, intravenous infusion over one hour

- Dose: ☐ 4mg/kg / ☐ 8mg/kg / ☐ 10mg/kg / ☐ 12mg/kg / ☐ _____mg/kg
  - ☐ round up to nearest whole vial
  - ☐ give exact dose
- Frequency: ☐ every 2 weeks / ☐ every 4 weeks / ☐ other: _____
- Route: ☑ intravenous
- Infuse over 1 hour

☑ Flush with 0.9% sodium chloride at the completion of infusion

☐ **Tocilizumab** (Actemra) injection

- Dose: ☐ 162mg / ☐ _____mg
- Frequency: ☐ weekly / ☐ every 2 weeks / ☐ every 3 weeks / ☐ other: _____
- Route: ☑ subcutaneous

☐ Patient required to stay for 30-min observation post procedure
☐ Patient is NOT required to stay for observation time
☐ Refills: ☐ Zero / ☐ for 12 months / ☐ _____

Perform test for latent TB; if positive, start treatment for TB prior to starting ACTEMRA. Monitor all patients for active TB during treatment, even if initial latent TB test is negative.
It is recommended that ACTEMRA not be initiated in patients with an absolute neutrophil count (ANC) below 2000 per mm3, platelet count below 100,000 per mm3, or who have ALT or AST above 1.5 times the upper limit of normal (ULN).
Laboratory monitoring—recommended due to potential consequences of treatment-related changes in neutrophils, platelets, lipids, and liver function tests.

Provider Name (Print) **Provider Signature** **Date**

REQUIRED DOCUMENTATION

☐ Recent Office notes (along with any therapies tried and outcomes) ☐ Current Medication ☐ History and Physical Report
☐ Lab Results ☐ Insurance Cards (front and back) ☐ Demographic Sheet

ATTACH REQUIRED LAB RESULTS (FOR NEW REFERRALS ONLY)
☐ ANA (SLE) ☐ Comprehensive Metabolic Panel, CBC with differential w/in past 3 months