Ascension Rx

Tocilizumab (Actemra & Biosimilars) Infusion Order Form

Patient Name: _____ **Date of Birth:** _____

Patient Phone #: _____ **Date:** _____

Therapy Status: ☐ New Start ☐ Continuation ☐ Restart **Last Dose:**_____

Height (inches)	Weight (kg)	Allergies

Diagnosis

ICD-10 Code(s): _____ J Code(s): _____

Labs (Recommended to be done within 30 days of first dose)

- ☐ Labs to be reviewed or ordered by infusion center
  - ☑ Baseline
    - ☑ TB screening (QuantiFERON or alternative)
    - ☑ Hepatitis Screening prior to therapy (HBsAg, HepB core Ab total, HCV)
    - ☑ CBC with Differential
    - ☑ CMP
    - ☑ Lipid Panel
  - ☑ Maintenance
    - ☐ Every 3 months
    - ☐ Other: _____
      - ☑ CBC with Differential
      - ☑ CMP
- ☐ Labs reviewed by ordering provider, ok to proceed (Labs last done on _____)
- ☐ Other: _____

Provider Information

Live vaccines should not be given concurrently

Nursing Orders

- ☑ Initial dose: Hold & notify provider if ANC < 2,000/mm^3, platelets < 100/mm^3, ALT or AST > 1.5 time ULN.
- ☑ Subsequent doses: Hold & notify provider if ANC < 1,000/mm^3, platelets < 100/mm^3, ALT or AST > 1.5 time ULN.
- ☑ Do not administer with an active infection, including clinically important localized infection, or if patient is taking antibiotics for current infection.

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- [x] Vital signs at baseline and every 30 minutes during infusion, unless patient has a history of infusion reaction, then every 15 minutes after baseline.
- [x] Use implanted port access, if available. If none, insert peripheral IV.
- [x] Pregnancy status: If uncertain, obtain HCG urine test for women 11 – 50 years prior to treatment.

Pre-Medications (Not routinely recommended, use only if clinically indicated)

- [ ] Acetaminophen 650 mg PO once
- [ ] Diphenhydramine 25 mg PO once
- [ ] Diphenhydramine 25 mg IV once
- [ ] Diphenhydramine 50 mg PO once
- [ ] Diphenhydramine 50 mg IV once
- [ ] Famotidine 20 mg IV once
- [ ] Famotidine 20 mg PO once
- [ ] Dexamethasone 20 mg IV once
- [ ] Dexamethasone 20 mg PO once
- [ ] Methylprednisolone 125 mg IV once
- [ ] Methylprednisolone 40 mg IV once
- [ ] Other: _____

IV Site Orders

- [x] Follow standard protocol for IV site management
- [x] In absence of standard protocol, follow the orders below:
  - [x] Sodium chloride 0.9% infusion 250 mL IV at 20 mL/hr PRN (carrier fluid/KVO)
  - [x] Start peripheral IV or access central line for infusion
  - [x] Sodium chloride 0.9% 10 mL flush to IV site as needed
  - [x] Heparin 50 units/5 mL flush to IV site as needed (central line only)
  - [x] Heparin 500 units/5 mL flush to IV site as needed (central line only)
  - [x] May use alteplase 2 mg intracatheter as needed for negative blood return of IV site

Medication Orders (select only one)

- [ ] Tocilizumab 4 mg/kg (_____mg) IV over 60 minutes (max dose: 800 mg) once every 4 weeks
- [ ] Tocilizumab 6 mg/kg (_____mg) IV over 60 minutes (max dose: 800 mg) once every 4 weeks
- [ ] Tocilizumab 8 mg/kg (_____mg) IV over 60 minutes (max dose: 800 mg) once every 4 weeks

Refills:
(Refills for one year from date of signature unless indicated)

- [ ] Zero
- [ ] For 12 months
- [ ] _____

To be completed by Infusion Center staff only:

Biosimilar substitution/Product Dispensed: _____ J-Code: _____

Rationale for Substitution:

- [ ] Payer-mandated substitution

3/20/2026

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- ☐ Financial stewardship
- ☐ Patient access / hardship

Pharmacy may adjust dose ±10% of ordered dose per approved protocol. Pharmacy may substitute a biosimilar based on insurance coverage.
Pharmacy may adjust diluent, volume, and infusion duration in accordance with local practice standards.

Emergency / Hypersensitivity Orders

- ☑ Notify provider for next steps once patient stabilized
- ☑ Follow standard orders for management of allergies and anaphylaxis reactions
- ☑ In absence of standard protocol, follow the orders below:
  - ☑ Nursing to stop infusion, maintain airway, place supine, elevate legs, O_2 2 L NC
  - ☑ Epinephrine 0.3 mg IM Once PRN anaphylaxis (first-line)
  - ☑ Diphenhydramine 25 mg IV q6h PRN itching/hives
  - ☑ Hydrocortisone 100 mg IV Once PRN hypersensitivity
  - ☑ Methylprednisolone 125 mg IV Once PRN hypersensitivity
  - ☑ Famotidine 20 mg IV Once PRN hives/itching
  - ☑ Albuterol inhaler 2 puffs Once PRN wheezing/SOB
  - ☑ Normal Saline 1000 mL IV bolus Once PRN hypotension

Infusion Center Staff

Please fax infusion records or discharge summary to: Fax Number _____

Provider Information

Provider Signature: _____ Date: _____

Provider Printed Name: _____ Provider NPI: _____

Provider Address: _____ Phone: _____ Fax: _____

All orders are valid for 1 year from the ordered date unless otherwise indicated