Ascension St. Vincent's Southside Infusion Center
Phone: 904-296-5994 Fax: 904-296-9070

Patient Name:_____
Date of Birth:_____
Patient Phone #:_____
Insurance:_____
Subscriber ID:_____

Tocilizumab (Actemra) Order Set

Fill out all information on this form and attach the following as appropriate:
-Copy of prescription/medical card (front and back) -Pertinent labs related to diagnosis and medication administration -Pertinent clinical/ progress notes and tests supporting diagnosis.
-Sign, date and fax to: 904-296-9070

General Information							
Height	_____ inches	**Weight**	_____ kg	**Allergies**	☐ NKDA	☐ List: _____	

Diagnosis	ICD 10 Code(s)	J Code	CPT Code
☐ Rheumatoid Arthritis ☐ Other: _____	☐ M06.00, M06.9, M05.9, M05.89 ☐ Other: _____	☑ J3262	☑ CPT Code: _____

Labs (prior to scheduling initial infusion)	Other Labs:
☑ Tb Test ☑ Hepatitis Panel ☑ Hepatic (Liver) Function Panel ☑ CBC with differential ☑ Lipid Panel ☑ ESR, CRP ☑ CMP	☐ _____ ☐ _____ ☐ _____ ☐ _____ ☐ _____

Nursing Orders	Pre-medications (not required)	
☑ Discharge patient when stable and meets protocol criteria	☐ Acetaminophen 975 mg PO, once	☐ Diphenhydramine 25 mg PO, once
Emergency/Anaphylaxis Order	☐ Cetirizine 10 mg PO, once	☐ Diphenhydramine 25 mg IV, once
☑ Follow standard orders for management of allergies and anaphylaxis reactions	☐ Dexamethasone 20 mg IV, once	☐ Other: _____
	☐ Ondansetron 4 mg IV, once	☐ Other: _____

Medication Orders

	Medication	Route	Dose	Frequency	Select Treatment Type
☑	Tocilizumab	IVPB	*over 60 mins* ☐ 4 mg/kg ☐ 8 mg/kg	Once	☐ Maintenance: Every 4 weeks for ____ dose(s) ☐ Other: _____

Order Comments: Maximum dose: 800mg. **Do NOT administer as a bolus or push.** Do NOT administer during an active infection, including localized infections.
*Pharmacy may adjust dose +/- 10% of calculated dose per Pharmacy and Therapeutics Committee approved protocol.

Infusion Center Staff Please fax infusion records or discharge summary to: **Fax Number** _____

Provider Signature		**Date**	
Provider Printed Name			