LOUIS H. MEDVED, MD
INFUSION THERAPY

Patient Name:

DOB:

Actemra® (tocilizumab) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided):

_____ Rheumatoid Arthritis (ICD-10)

_____ Giant Cell Arteritis (ICD-10)

_____ Cytokine Release Syndrome (ICD-10)

_____ Other: _____ (ICD-10)

Nursing Orders:

- Hold infusion and notify provider for:
  - Signs or symptoms of illness or active infection
  - Planned/recent surgical procedures
  - New onset abdominal pain
  - Neurological changes
  - Recent live vaccinations
  - ANC less than or equal to 1000 mm^3
  - PLT less than or equal to 100,000 mm^3
  - AST or ALT greater than 1.5x ULN
- Measure and record weight at each appointment.
- If infusion-related reaction occurs, stop infusion and follow Hypersensitivity Reaction Management Protocol as clinically indicated.

Premedications:

☐ Tylenol 500 mg PO PRN ☐ Loratadine 10 mg PO PRN ☐ Solu-Medrol 125 mg IVP

☐ Benadryl 25 mg PO PRN ☐ Other: _____

Lab orders:

☐ CBC w/diff, AST, ALT at Week 4, then every 3 months ☐ Lipid Panel at Week 4

☐ Other: _____

Administer tocilizumab ☐ 4 mg/kg ☐ 8 mg/kg x current weight (_____ kg) = _____ mg in 100 mL 0.9% sodium chloride and administer of a period of over 60 minutes.

Dose may be rounded by up to 10% to nearest vial size per protocol. Provider check here (☐) to PROHIBIT dose rounding.

Frequency (chose one):

☐ Every 4 weeks ☐ Every _____ weeks

Provider (please print): _____

Provider signature: _____ Date: _____

Revised 10/24/19. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.