Place Sticker Here

Tocilizumab (Actemra) Treatment Plan

Patient Name: _____ DOB: _____

Height (cm): _____ Weight (kg): _____ Allergies: _____

Diagnosis (select one and complete the 2nd and 3rd digits to complete the ICD-10 code):

□ M05.___ Rheumatoid Arthritis with Rheumatoid factor

□ M06.___ Rheumatoid Arthritis without Rheumatoid factor

□ Other: ICD 10 Code: _____ Diagnosis Description: _____

Pre-Medications: **administered 30 minutes prior to infusion**

□ None

□ Acetaminophen 650 mg PO

□ Diphenhydramine: Dose: □ 25 mg □ 50 mg Route: □ PO or □ IVP

□ Methylprednisolone: Dose: □ 40 mg or □ 125 Route: IVP

□ Famotidine: Dose: 20 mg Route: □ PO or □ IVPB

□ Other (include drug, dose, and route): _____

Drug Orders:

- Tocilizumab (Actemra) (J3262) per 100 mL Sodium Chloride 0.9% IV to infuse over 1 hour
  - □ Induction: 4 mg/kg and then maintenance dose of □ 4 mg/kg or □ 8 mg/kg every 4 weeks
  - □ Maintenance: □ 4 mg/kg or □ 8 mg/kg every 4 weeks
- Order Duration: Six months unless otherwise specified (Other: _____)

Lab Orders: **Selected labs are drawn with first dose and then every 12 weeks thereafter. Standard parameters listed on following page**

□ CBC w/ Diff

□ CMP

□ LFTs

□ Cholesterol level

Standing Orders:

- Infusion Reaction Protocol (CPOE-1396) will be activated if any hypersensitivity reaction occurs, including anaphylaxis. Infusion will be stopped and physician notified.

Physician Signature: _____ **Date:** _____

Physician Name: _____ **Phone:** _____

Pre-Screening Requirements:

- Provide TB screening results (PPD or QuantiFERON Gold Test) prior to start of therapy and within last 12 months
- Provide Hepatitis screening (Hepatitis B Surface Antigen) prior to start of therapy and within last 12 months
- Lab results (CBC w/ Diff, LFTs, Cholesterol) within last 30-60 days if available. If not provided, they will be drawn prior to treatment as ordered by physician

Lab Parameters:

- If ANC= 500-1000 cells/mm^3, interrupt tocilizumab dosing and have patient return in 4 weeks. Tocilizumab may be resumed at 4 mg/kg when ANC> 1000 cells/mm^3. May increase to 8 mg/kg as clinically appropriate. If ANC <500 cells/mm^3, discontinue tocilizumab and notify physician.
- If Platelet count= 50,000-100,000 cells/mm^3, interrupt tocilizumab dosing and have patient return in 4 weeks. Tocilizumab may be resumed at 4 mg/kg when Platelet count> 100,000 cells/mm^3. May increase to 8 mg/kg as clinically appropriate. If Platelet count< 50,000 cells/mm^3, discontinue tocilizumab and notify physician.
- If liver enzymes are > 3-5 x upper limit normal, hold tocilizumab and notify physician.
- If Cholesterol level is elevated, notify physician for monitoring.

Previous Therapies:

- For new patient referrals, please send history and physical and most recent physician note with completed plan
- If patient has previously received tocilizumab at another facility, please provide last date received: _____
- If patient has previously received another biologic therapy, please provide the name: _____

and the last date received: _____

Insurance/Authorization Information:

Insurance Type: _____

Insurance Authorization Reference Number: _____

Date Obtained: _____ Authorization Valid Until: _____

Additional Notes: _____

Fax completed Treatment Plan with authorization information to McLeod Infusion Services at the number below or call with any questions.

Seacoast: 843-366-2224 (Fax)

843-366-3626 (Phone)