Oregon Health & Science University Hospital and Clinics Provider's Orders PO7071 ADULT AMBULATORY INFUSION ORDER **Tocilizumab (ACTEMRA) Infusion** Page 1 of 3	ACCOUNT NO. MED. REC. NO. NAME BIRTHDATE *Patient Identification*

ALL ORDERS MUST BE MARKED IN INK WITH A CHECKMARK (✓) TO BE ACTIVE.

Weight: _____kg **Height:** _____cm

Allergies: _____

Diagnosis Code: _____

Treatment Start Date: _____ **Patient to follow up with provider on date:** _____

****This plan will expire after 365 days at which time a new order will need to be placed****

GUIDELINES FOR ORDERING

1. Send **FACE SHEET and H&P or most recent chart note**.
2. Hepatitis B (Hep B surface antigen and core antibody total) screening must be completed prior to initiation of treatment and the patient should not be infected. Please send results with order.
3. A Tuberculin test must have been placed and read as negative prior to initiation of treatment (PPD or QuantiFERON Gold blood test). Please send results with order. If result is indeterminate, a follow up chest X-ray must be performed to rule out TB. Please send results with order.
4. It is recommended that tocilizumab not be initiated in patients with an ANC less than 2000/mm3, platelet count below 100,000/mm3, or who have ALT or AST greater than 1.5x the upper limit of normal.
5. Do not administer in patients with an active infection, including localized infections. Hold treatment if a patient develops a serious infection, an opportunistic infection, or sepsis.
6. Patients should have regular monitoring for TB, infection, malignancy, neutropenia (ANC), thrombocytopenia, elevated lipids, and liver abnormalities throughout therapy.
7. Max dose: 800 mg.

PRE-SCREENING: (Results must be available prior to initiation of therapy):

- ☐ Hepatitis B surface antigen and core antibody total test results scanned with orders.
- ☐ Tuberculin skin test or QuantiFERON Gold blood test results scanned with orders.
- ☐ Chest X-Ray result scanned with orders if TB test result is indeterminate.

LABS:

- ☐ CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ CMP, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Lipid set, Routine, ONCE, every ____ (visit)(days)(weeks)(months) – *Circle One*
- ☐ Labs already drawn. Date: _____

NURSING ORDERS:

1. TREATMENT PARAMETER – Hold treatment and contact provider if Hepatitis B surface antigen or core antibody total test result is positive, TB test result is positive, or if screening has not been performed.
2. VITAL SIGNS – Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion.
3. Follow facility policies and/or protocols for vascular access maintenance with appropriate flush solution, declotting (alteplase), and/or dressing changes

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PRE-MEDICATIONS: (Administer 30 minutes prior to infusion)
Note to provider: Please select which medications below, if any, you would like the patient to receive prior to treatment by checking the appropriate box(s)

☐ loratadine (CLARITIN) tablet, 10 mg, oral, ONCE

MEDICATIONS:

tocilizumab (ACTEMRA) _____ mg/kg = _____ mg in sodium chloride 0.9% 100 mL IV, ONCE over 60 minutes

Max dose: 800 mg

Interval: ***(must check one)***

☐ Once
☐ Every _____ weeks x _____ doses

AS NEEDED MEDICATIONS:

☐ acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for headache, fever, body aches or chills
☐ diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching

HYPERSENSITIVITY MEDICATIONS:

1. NURSING COMMUNICATION – If hypersensitivity or infusion reactions develop, temporarily hold the infusion and notify provider immediately. Administer emergency medications per the Treatment Algorithm for Acute Infusion Reaction (OHSU HC-PAT-133-GUD, HMC C-132). Refer to algorithm for symptom monitoring and continuously assess as grade of severity may progress.
2. diphenhydrAMINE (BENADRYL) injection, 25-50 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction
5. famotidine (PEPCID) injection, 20 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity or infusion reaction

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By signing below, I represent the following:
I am responsible for the care of the patient (*who is identified at the top of this form*);
I hold an active, unrestricted license to practice medicine in: ☐ Oregon ☐ _____ (*check box that corresponds with state where you provide care to patient and where you are currently licensed. Specify state if not Oregon*);

My physician license Number is # _____ (MUST BE COMPLETED TO BE A VALID PRESCRIPTION); and I am acting within my scope of practice and authorized by law to order Infusion of the medication described above for the patient identified on this form.

Provider signature: _____ **Date/Time:** _____

Printed Name: _____ **Phone:** _____ **Fax**: _____

Central Intake:

Phone: 971-262-9645 (providers only) Fax: 503-346-8058

Please check the appropriate box for the patient's preferred clinic location:

☐ **Beaverton**
OHSU Knight Cancer Institute
15700 SW Greystone Court
Beaverton, OR 97006
Phone number: 971-262-9000
Fax number: 503-346-8058

☐ **NW Portland**
Legacy Good Samaritan campus
Medical Office Building 3, Suite 150
1130 NW 22nd Ave
Portland, OR 97210
Phone number: 971-262-9600
Fax number: 503-346-8058

☐ **Gresham**
Legacy Mount Hood campus
Medical Office Building 3, Suite 140
24988 SE Stark
Gresham, OR 97030
Phone number: 971-262-9500
Fax number: 503-346-8058

☐ **Tualatin**
Legacy Meridian Park campus
Medical Office Building 2, Suite 140
19260 SW 65th Ave
Tualatin, OR 97062
Phone number: 971-262-9700
Fax number: 503-346-8058

Infusion orders located at: www.ohsuknight.com/infusionorders