



Oregon Health & Science University
Hospital and Clinics Provider's Orders

PO7071



ADULT AMBULATORY INFUSION ORDER
Tocilizumab (ACTEMRA)

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. A Tuberculin test must have been placed and read as negative within the past year (or QuantiFERON Gold blood test).
3. 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.
4. Patients should not have an active ongoing infection at the onset of tocilizumab therapy.
5. Patients should have regular monitoring for TB, infection, malignancy, neutropenia (ANC), thrombocytopenia, elevated lipids, and liver abnormalities throughout therapy.

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

- Hepatitis B Surface AG, serum, Routine, ONCE
- Hepatitis B Core AB Qual, serum, Routine, ONCE

OR

- Hepatitis B surface antigen and core antibody test results scanned with orders

- Tuberculin Test Result. Date: _____ Positive / Negative

OTHER:

- Tuberculin (TUBERSOL, APLISOL) injection, 5 units, intradermal, ONCE, prior to initiation of therapy if not already done

LABS:

- CBC with differential, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- CMP, Routine, ONCE, every _____ (visit)(days)(weeks)(months) – *Circle One*
- Liver Set (AST, ALT, BILI TOTAL, BILI DIRECT, ALK PHOS, ALB, PROT TOTAL), 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. VITAL SIGNS – Monitor and record vital signs, tolerance, and presence of infusion-related reactions prior to infusion and at the end of infusion.
2. 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)

1. acetaminophen (TYLENOL) tablet, oral, ONCE, every visit
 - 650 mg
 - 325 mg
 - 500 mg
 - 1000 mg
2. diphenhydrAMINE (BENADRYL) capsule, oral, ONCE, every visit
 - 25 mg
 - 50 mg
3. loratadine (CLARITIN) tablet, oral, ONCE, every visit
(Choose as alternative to diphenhydramine if needed)
 - 10 mg
 - 5 mg

MEDICATIONS:

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

Max dose: 800 mg

Pharmacist will round dose to nearest 100 mg vial and modify during order verification

Interval: (must check one)

- Once
- Every _____ weeks x _____ doses

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 (Policy HC-PAT-133-GUD). 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 x1 dose for hypersensitivity reaction
3. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
4. hydrocortisone sodium succinate (SOLU-CORTEF) injection, 100 mg, intravenous, AS NEEDED x 1 dose for hypersensitivity reaction

AS NEEDED MEDICATIONS:

- acetaminophen (TYLENOL) tablet, 650 mg, oral, EVERY 4 HOURS AS NEEDED for fever
- diphenhydrAMINE (BENADRYL) capsule, 25 mg, oral, EVERY 4 HOURS AS NEEDED for itching



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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:** _____

OLC Central Intake Nurse:

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