ADULT AMBULATORY INFUSION ORDER
Tocilizumab (ACTEMRA) Infusion

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.
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.

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
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 (Policy 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 x1 dose for hypersensitivity reaction

3. famotidine (PEPCID) injection, 20 mg, intravenous, 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

5. EPINEPHrine HCl (ADRENALIN) injection, 0.3 mg, intramuscular, AS NEEDED x1 dose for hypersensitivity reaction
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.

<table>
<thead>
<tr>
<th>Provider signature: ________________________________</th>
<th>Date/Time: ________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Printed Name: ________________________________</td>
<td>Phone: ____________________________ Fax:__________</td>
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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