IVHEALTH CENTER

Fax:_____Phone:_____

Name _____

DOB_____ **ID#**_____

Weight _____ **Date** _____

Tocilizumab (ACTEMRA)

Diagnosis: (ICD-10 code) _____ - Description_____

For Provider

- Hepatitis B screening: Y or N
- PPD test: Y or N
- Avoid vaccines within 90 days of infusion therapy.

Infusion Medication

Tocilizumab (ACTEMRA) in 0.9% sodium chloride 100ml.

Dose*:* (please circle) 4mg/kg 8mg/kg
Route*:* IV over 60 minutes
Frequency*:* Once every 4 weeks

Pre-Meds

(Please circle)

Acetaminophen (TYLENOL) tablet
Dose: 650 mg PO 30 minutes prior to infusion. Or PRN

Hydroocortisone (Solu-Cortef)
Dose: 25mg-50mg PO (only if patient experiences reaction refractory to acetaminophen and cetirizine)

Cetirizine (ZYRTEC) tablet
Dose: 10 mg PO 30 minutes prior to infusion.

Other: _____

Labs

- CBC, CMP with differential every 4 weeks
- Check Lipid panel every 4 weeks after initial infusion. Then every 6 months after initial infusion.

Additional Orders

Provider Signature: _____ **Date:** _____

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