

Tocilizumab (Actemra®) Prescriber Order and Referral Form

Pharmacists with the Froedtert Pharmacy will be supporting this patient's infusion medication management.
Fax completed form, insurance information and clinical documentation to 414-260-7368.

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Height: _____ inches cm Weight: _____ lbs kg

Clinical Information

Primary Diagnosis Description: _____ ICD-10 Code(s): _____

Is this the first dose? Yes - Date of first dose: _____ No - Date of next dose: _____

TB Status
 PPD (negative) – date: _____ Active TB Unknown
 Last chest x-ray – date: _____ Other _____
 Past positive TB infection, course taken: _____

Tocilizumab (Actemra®) Prescription

Tocilizumab (Actemra®) or biosimilar based on the preferred brand per insurance coverage, refill as directed x 1 year

Initial Dose:
 Infuse _____ mg/kg IV over 60 minutes every 4 weeks – max 800 mg.
 Inject 162 mg once every week or every other week.
 Other: _____

Ancillary Orders

Anaphylaxis Orders

Treat per Froedtert Home and Specialty Infusion protocol.

Medication Orders

- Acetaminophen 650 mg PO 30 min before infusion, may repeat every 3 to 4 hours as needed for fever or mild discomfort. Patient may use own supply or patient may decline.
- Diphenhydramine 25 mg PO 30 min before infusion, may repeat every 4 to 6 hours as needed for mild to moderate allergic reactions. Patient may use own supply or patient may decline.
- Methylprednisolone Succinate 40 mg IV push 20 minutes prior to infusion.
- Other: _____

IV Access and Flush Orders: RN to access and monitor venous infusion line as indicated below:

- Peripheral: Flush with 0.9% NS - 10 ml pre/post-use.
- Implanted Port or PICC: Flush with 0.9% NS - 10 ml pre/20 ml post-use and 10 ml pre/20 ml post-lab

Lab Orders

- No labs ordered at this time.
- Other: _____

Skilled nurse to administer doses intravenously in the home or alternate care setting. Refill above ancillary orders as directed x 1 year.

I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment.

Prescriber Signature _____ Date _____ Time _____

Prescriber Name _____ Phone _____ Fax _____

Address _____ NPI _____

City, State, Zip _____ Office Contact _____

