



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

PO9031



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/mm<sup>3</sup>, platelet count below 100,000/mm<sup>3</sup>, 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, dec clotting (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:** \_\_\_\_\_

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

**Hillsboro Medical Center**  
Infusion Services  
364 SE 8th Ave, Medical Plaza Suite 108B  
Hillsboro, OR 97123  
Phone number: (503) 681-4124  
Fax number: (503) 681-4120

**Adventist Health Portland**  
Infusion Services  
10123 SE Market St  
Portland, OR 97216  
Phone number: (503) 261-6631  
Fax number: (503) 261-6756

**Mid-Columbia Medical Center**  
Celilo Cancer Center  
1800 E 19th St  
The Dalles, OR 97058  
Phone number: (541) 296-7585  
Fax number: (541) 296-7610