ALL ORDERS MUST BE SIGNED, DATED AND TIMED BY PHYSICIAN

Allergies/Reactions:

❑ Puyallup Infusion Center - Fax: 253-697-5066
❑ Allenmore Ambulatory Infusion Services - Fax: 253-864-4052
❑ Auburn Infusion Services - Fax: 253-876-8282
❑ Gig Harbor Infusion Services - Fax: 253-530-8069
❑ DHEC Infusion Center - Fax: 509-755-5845
❑ North Spokane Infusion Center - Fax: 509-232-2531

ORDERS WITH CHECK BOXES When an order is optional (those with check boxes), physicians are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.

Tocilizumab (Actemra) or other biosimilar

Patient Name:_____ Requested Date of Service: _____ /_____ /_____

Date of Birth: _____ /_____ /_____ Patient Phone Number: (_____) _____ - _____ ❑ May leave message

ICD -10 Code:

Diagnosis: ❑ Rheumatoid Arthritis ❑ _____

❑ Other_____ ❑ _____

Required: H&P with documentation to support above diagnosis including ICD-10 code and supporting labs
If required documentation not received with order, scheduling of treatment will be delayed until complete information is available.

Baseline labs required for initial dosing:
- CBC & CMP (do not initiate if ANC <2000; platelets <100k, and/or liver enzymes > 1.5 x ULN)
- Latent TB testing

Date_____ Results_____

Maintenance Labs required:
- CBC & CMP every 8 weeks
  - Hold infusion and notify provider for ANC <1000; platelets <100k; and/or liver enzymes >1.5 x ULN
- Lipid panel at 8 weeks, then every 6 months
- Annual latent TB testing

☑ **IV Access:** Access and/or maintain IV site in accordance with MHS IV Therapy P&P, Peripheral IV device site selection, insertion, maintenance, and discontinuation and maintenance of central venous catheters-flushing, dressing changes and removal.

Patient weight = _____ lb/kg (required)

TREATMENT REGIMEN (pharmacist to add MHS or insurance preferred product):
Tocilizumab or other biosimilar: administered in 100 mL NS infused over 60 minutes

❑ 4 mg/kg = _____mg (maximum dose = 800 mg) IV every 4 weeks

❑ 8 mg/kg = _____ mg (maximum dose = 800 mg) IV every 4 weeks

☑ **Vital Signs:** Check vital signs prior to and after infusion.
Contact provider if systolic BP >180; diastolic BP >100; systolic BP <90; HR >110; temp >38C (100.4F)

If Hypersensitivity reaction (fever, chills, hypotension, rigors, itching, rash, etc.):
- Consult MultiCare hypersensitivity guideline for treatment management
- Notify provider of reaction, assessment and need for further orders

Code Status: Please note, patients will be considered FULL Code unless marked otherwise. If the patient has a POLST, advance directive or living will, please include a copy with the orders.

Was consent obtained: ❑ Yes ❑ No (if yes, please send DOCUMENTATION of consent with order)

Provider Signature	Print Name	Date	Time

Another brand of drug, identical in form and content, may be dispensed unless checked ❑ **Order expires in 12 months****

Patient Identification - Always Attach Patient Label

Name:

MRN #:

CSN #:

Age / Sex and Gender:

Pre-printed Order
TOCILIZUMAB (Actemra)

MultiCare

78-0019-1MR (Rev. 7/24)