

Infusion

Tocilizumab (Actemra)



PATIENT INFORMATION

Patient Name: _____ DOB: _____ Provider: _____

Date: _____ Allergies: _____ Pt Weight: _____ kg

ICD-10: _____

(Check diagnosis)

Rheumatoid Arthritis Giant cell arteritis Cytokine release syndrome

ORDERS PRECEDED BY A REQUIRE A TO INITIATE THE ORDER.

Tocilizumab _____ mg/kg (_____ mg) (Max dose 800mg) IV Protect from light. Infuse over 60 minutes.

FREQUENCY: (select one)

Every 4 weeks Every 8 weeks

Laboratory: _____ CBC _____ LFT _____ Fasting lipid panel (after second dose. do not wait for results to treat for same day draw)

QFG TB testing every 12 months while on therapy. Most current TB test & type: _____ Results: _____ Date: _____

Other Laboratory tests: _____

_____ **No premeds**

PRE-MEDS (DRUG, DOSE, AND ROUTE):

Diphenhydramine (check one) 25mg IV 50mg IV

Acetaminophen PO (check one) _____ 325mg OR 500 mg _____ Other dose

Ondansetron 4mg IV PRN Nausea

Other (drug, dose, route and frequency) _____

OTHER ORDERS

Follow SH Infusion reaction protocol for symptom of infusion reaction. Notify provider if initiated.

Contact MD prior to infusion if patient reports changes from previous infusion related to: active infection, illness (*with or without fever*) active cancer, CHF, previous infusion reactions to Tocilizumab. Notify MD of all infusion reactions.

Notify physician if infusion NOT given or patient status is 'No Show' for his or her appointment.

Hold infusion and notify Provider for for ANC of 500-1000, Plt count 50,000 to 100,000, or LFTs 1 to 3x ULN

Other: _____

PATIENTS WITH CENTRAL LINE ACCESS:

Select one: Patient has a PICC Implanted port Other CVAD

Central line care per Salem Health CVAD Access Policy. (*Lippincott*)

Alteplase per Salem Health Central Venous Access Device declotting (*Lippincott*) for S/sx of occlusion: Inability to infuse fluids, no blood return, increased resistance when flushing, increased occlusion/high-pressure alarm when using an infusion pump, sluggish gravity flow

1 View Chest X-ray to verify PICC tip location PRN for: Catheter migration greater than 5 cm, signs and symptoms of tip malposition (*occlusion unresolved by Alteplase, discomfort in the arm, neck or chest, unusual sensations or sounds when flushing, neck vein engorgement, or heart palpitations.*) Notify Physician or Provider

Provider Signature

Provider Printed Name

Date:

salemhealth.org

Infusion

Appointment line: 503-814-4638

(M-F: 8 a.m.-4:30 p.m., Sat & Sun 8 a.m.-2:30 p.m.)

Fax: 503-814-1465

PATIENT LABEL