

Place patient identification
sticker here

**DOCTOR'S ORDER SHEET –
PHARMACY – ACTEMRA (tocilizumab)**

Allergies: NKA Height _____ Weight _____ kg

****UNAPPROVED ABBREVIATIONS****

QD, QOD, MgSO₄, MSO₄, MS, IU, U or -u, ug, Use of a Trailing Zero (X.0mg), Lack of a Leading Zero(Xmg)

| DATE | TIME | ORDERS | NURSE SIGNATURE |
|------|------|--|-----------------|
| | | <input type="checkbox"/> Assign to Outpatient status | |
| | | PREMEDICATIONS: | |
| | | 0.9% sodium chloride (NS) IV at KVO | |
| | | <input type="checkbox"/> No pre-medications necessary | |
| | | <input type="checkbox"/> methylprednisolone sodium succinate injection _____ mg IV x 1 dose 30 mins prior to infusion | |
| | | <input type="checkbox"/> diphenhydramine _____ mg IV x1 dose 30 mins prior to infusion | |
| | | <input type="checkbox"/> diphenhydramine _____ mg PO x 1 dose 30 mins prior to infusion | |
| | | <input type="checkbox"/> acetaminophen 650mg PO x 1 dose 30 mins prior to infusion | |
| | | MEDICATION: | |
| | | Actemra (tocilizumab) in 0.9% NS 100ml IV infusion | |
| | | Dose: <input type="checkbox"/> 4mg/kg = Total Dose _____ mg | |
| | | <input type="checkbox"/> 8mg/kg = Total Dose _____ mg | |
| | | Route: Intravenous | |
| | | Frequency: Once every 4 weeks | |
| | | Infusion Duration: 60 minutes | |
| | | <i>If infusion-related reaction:</i> | |
| | | 1.) STOP infusion immediately; | |
| | | 2.) Increase 0.9% sodium chloride (NS) infusion to wide open rate; | |
| | | 3.) Administer PRN medications per infusion reaction medication ordered; | |
| | | 4.) Call Max Cart; | |
| | | 5.) Notify MD | |
| | | INFUSION REACTION MEDICATIONS: | |
| | | albuterol inhalation nebulizer solution 2.5mg/0.5ml (concentrated solution) | |
| | | (Note: dilute with 2.5ml of NS for an albuterol 2.5mg/3ml dose) | |
| | | <i>Dose: 2.5mg via nebulizer as needed for shortness of breath/wheezing</i> | |
| | | diphenhydrAMINE injectable | |
| | | <i>Dose: 25mg IV x 1 dose for urticaria, pruitis, shortness of breath. May repeat in 15 minutes if symptoms not resolved</i> | |
| | | EPINEPHrine 1mg/ml (1:1000) injectable | |
| | | <i>Dose: 0.3mg IM x1 dose as needed for anaphylaxis</i> | |
| | | methylPREDNISolone sodium succinate 125mg injection | |
| | | <i>Dose: 125mg IV x1 dose as needed for hypersensitivity</i> | |
| | | NURSING ORDERS: | |
| | | • Weight should be recorded at every visit. Notify physician if weight changed 10% or greater from baseline | |
| | | • Ensure patient has had TB test or QuantiFERON-TB assay for latent TB prior to start of treatment | |
| | | • Continue with infusion only if patient meets the following criteria: <ul style="list-style-type: none"> ○ ANC ≥ 2,000 (first dose) or ≥ 1,000 (subsequent doses) ○ Platelets ≥ 100,000 ○ AST/ALT < 1.5 x ULN | |
| | | • Verify lipid panel drawn prior to initial therapy, at 4 to 8 weeks after initial treatment and every 6 months during treatment. If lipid panel not drawn prior to treatment, instruct patient to have labs drawn and notify provider, but proceed with infusion. | |
| | | • Do not administer tocilizumab and notify provider if patient has a temperature >100°F, complains of symptoms of acute viral or bacterial illness, or if patient is taking antibiotics for current infection | |
| | | • Monitor patient for signs/symptoms of hypersensitivity during infusion and for 30 mins post-infusion | |
| | | • Discontinue IV line when therapy complete and patient stabilized | |

REFERENCES: Actemra Prescribing Information

USE BALL POINT PEN FAX TO PHARMACY

Qualified Medical Provider signature

Date

Time

