RED RIVER HEALTH
Ambulatory Infusion Clinic

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ACTEMRA (tocilizumab) Infusion Orders

Patient Name: DOB: ☐ M ☐ F

☐ NKDA Allergies:

☐ New Start therapy ☐ Continuation of Therapy Date of last dose (if applicable):

Ordering Provider: Provider NPI:

Practice Phone: Practice Fax:

Diagnosis *(please provide ICD-10 code)*:

☐ _____ Rheumatoid Arthritis (RA)
☐ _____ Giant Cell Arthritis (GCA)
☐ _____ Polyarticular Idiopathic Arthritis >2 yo (PJIA)
☐ _____ Systemic Juvenile Idiopathic Arthritis (SJIA)
☐ _____ Cytokine Release Syndrome (CRS)
☐ _____ _____ *(other)*

Pre-Medication:

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ Diphenhydramine 25mg IVP
☐ Other: _____

Required Documents:

☑ Patient Demographic Sheet
☑ Clinical/Progress notes, labs, tests supporting primary diagnosis *(please attach)*
☑ TB Status & Date *(please attach results)*
☑ HepB Status & Date *(please attach results)*

ACTEMRA ORDERS:

Dosing: ☑ Mix in 100ml 0.9% sodium chloride and administer via IV infusion over 1 hour

☐ 4 mg/kg ☐ 8 mg/kg ☐ 10 mg/kg ☐ Other: _____ **Pt. weight:** _____

(ensure unit of measure is noted)

Frequency:

☐ every 2 weeks ☐ every 4 weeks ☐ Other: _____

Refills: _____ *(if not indicated, Rx will expire one year from date signed)*

Red River Health Standing Orders:

☑ Provide treatment under Red River Health's Biologic Therapy Policy and Adverse Reaction Management Protocol. **Copy can be provided per request.*

Ordering Provider Signature: Date: