ALL ORDERS MUST BE SIGNED AND DATED BY THE REFERRING PROVIDER	
ALLERGIES/REACTIONS (REQUIRED):	Yakima Outpatient Infusion Care 808 N 39th Ave Yakima WA 98902 Phone: 509-575-1174 Fax: 509-577-5021
ORDERS WITH CHECK BOXES	When an order is optional (those with check boxes), providers are responsible for indicating a check mark in the box next to the order. Orders left unchecked will not be initiated.
CODE STATUS	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.

TOCILIZUMAB (Actemra)

Patient Name:_____ Requested Start Date: _____/_____/_____
Date of Birth:_____/_____/_____ Patient Weight: _____ kg Patient Height: _____

DIAGNOSIS & ICD-10 CODE:

- ❑ Rheumatoid Arthritis (ICD-10: _____)
- ❑ Systemic onset juvenile chronic arthritis (ICD-10: _____)
- ❑ Cytokine release syndrome (ICD-10: _____)
- ❑ Temporal arteritis (ICD-10: _____)
- ❑ Other: _____ (ICD-10: _____)

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

REQUIRED BASELINE LABS & INFORMATION:

- ✓ CBC & CMP
- ✓ Negative Latent TB Test (Date: _____ | ❑ QuantiFERON Gold | ❑ PPD | ❑ Chest X-Ray | ❑ Other: _____)

ROUTINE LABS: ❑ CMP | ❑ CBC w/ diff | ❑ ANC | ❑ LFT | ❑ CRP | ❑ Lipid Panel | ❑ ESR | ❑ Other: _____
ROUTINE LAB FREQUENCY: ❑ Each Infusion | ❑ Annually | ❑ Other: _____

ACCESS: *Access and maintain IV site or Port-A-Cath in accordance with the appropriate MYM OIC P&Ps*

TREATMENT REGIMEN: *(another brand of drug, identical in form and content may be dispensed unless "DAW" or "BRAND ONLY" is written next to the drug name)*

✓ **PRE-MEDICATIONS** – Give 30 minutes prior to infusion
- ❑ Acetaminophen 650 mg PO x1
- ❑ Diphenhydramine 25 mg PO x1
- ❑ Diphenhydramine 50 mg IV x1
- ❑ Loratadine 10 mg PO x1
- ❑ Methylprednisolone sodium succinate 125 mg IV x1
- ❑ Other: _____

✓ **TOCILIZUMAB (ACTEMRA) INTRAVENOUS INFUSION** – Max dose = 800 mg (Round to nearest vial size)
- ❑ 4 mg/kg x _____ kg = _____ mg in 100 mL normal saline IV every 4 weeks
- ❑ 8 mg/kg x _____ kg = _____ mg in 100 mL normal saline IV every 4 weeks
- ❑ Other: _____ mg in 100 mL normal saline IV every _____ weeks

MONITORING: Vitals at baseline and at completion of infusion.
SUPPORTIVE CARE: Administer hypersensitivity reaction/anaphylaxis management per MYMH OIC protocol as necessary.

DISCHARGE: 30 minutes after infusion is complete when vital signs are stable and hypersensitivity symptoms are absent. Waiting period can be waived by patient on subsequent infusions.

Provider Signature: _____ Date: _____
Print name: _____ Phone # _____ Fax # _____

❑ NEW REFERRAL ❑ UPDATED REFERRAL ****Expires 12 months from written date****

Patient Identification - Attach Patient Label

Name:

MRN:

Age / Sex and Gender:

TOCILIZUMAB (Actemra)

MultiCare

Yakima Memorial Hospital