Actemra
(tocilizumab)

Advanced Infusion Care Centers

PATIENT DEMOGRAPHIC INFORMATION

Patient Name: _____ Phone: _____

Date of Birth: _____ Address: _____

Allergies ☐ See List ☐ NKDA City, State, Zip: _____

Weight: _____ ☐ kg ☐ lbs Height: _____ ☐ in ☐ cm Email: _____

PRIMARY DIAGNOSIS

☐ Other giant cell arteritis (M31.6)
☐ Rheumatoid arthritis, unspecified (M06.9)
☐ Rheumatoid arthritis without rheumatoid factor, multiple sites (M06.09)
☐ Rheumatoid arthritis without rheumatoid factor, unspecified (M06.00)
☐ Other: _____

PRESCRIPTION

Actemra or biosimilar (Tyenne, Tofidence) may be selected to obtain payor approval. To prohibit auto-substitution, please indicate specific brand required _____

☐ Tocilizumab 4mg/kg IV every 4 weeks for _____ doses, followed by 8mg/kg IV every 4 weeks thereafter x 1 year
☐ Tocilizumab 4mg/kg IV every 4 weeks x 1 year *****DOSE NOT TO EXCEED 800MG IN RA/CRS DIAGNOSIS*****
☐ Tocilizumab 6mg/kg IV every 4 weeks x 1 year *****DOSE NOT TO EXCEED 600MG IN GCA DIAGNOSIS*****
☐ Tocilizumab 8mg/kg IV every 4 weeks x 1 year
☐ Other dose: _____ mg IV every 4 weeks x 1 year ☐ Other: _____

Has patient received any doses of this medication in the past? ☐ Yes ☐ No

REQUIRED DOCUMENTATION

- Insurance Card
- H&P
- Patient Demographics
- Medication List
- Most recent labs
- TB Screening within past 12 months (attach results)
- ANC
- Platelet count
- Baseline LFTs and Lipid Panel

ANCILLARY ORDERS

ADVERSE REACTION & ANAPHYLAXIS ORDERS

☑ Administer acute infusion and anaphylaxis medications per Advanced Infusion Care Centers' protocol. *(See aiscaregroup.com for detailed policy)*
☐ Other: Please fax other reaction orders if checking this box

PRE-MEDICATION ORDERS PROTOCOL

☐ Per infusion center protocol: No recommended standard pre-meds for Tocilizumab
☐ Provider Prescribed: _____

LINE CARE ORDERS

☑ Start PIV/Access CVC ☑ Flush device per Advanced Infusion Care Centers' protocol *(See aiscaregroup.com for detailed policy)*
☐ Other Flush Orders: Please fax other line care orders if checking this box

LAB ORDERS—PLEASE INCLUDE FREQUENCY

☐ Absolute Neutrophil Count at month 2 and every 3 months thereafter
☐ Platelet Count at month 2 and every 3 months thereafter ☐ LFTs at month 2 and every 3 months thereafter
☐ Please list any labs to be drawn by the infusion clinic: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ Phone: _____

NPI: _____ Fax: _____

Office Contact Person: _____ Email: _____

Prescriber Signature: _____ Date: _____

I certify that the use of the indicated treatment is medically necessary, and I will be supervising the patient's treatment.