Spectrum Health Helen DeVos children's hospital

Physician's Orders TOCILIZUMAB - PEDIATRIC, OUTPATIENT, INFUSION CENTER

Patient Name
DOB
MRN
Physician
FIN

Defaults for orders not otherwise specified below:
- ☐ Interval: Every 7 days
- ☐ Interval: Every 14 days
- ☐ Interval: Every 21 days

Duration:
- ☐ Until date: _____
- ☐ 1 year
- ☐ _____# of Treatments

Anticipated Infusion Date_____ ICD 10 Code with Description_____

Height_____(cm) Weight_____(kg) Allergies_____

Provider Specialty

☐ Allergy/Immunology	☐ Infectious Disease	☐ OB/GYN	☐ Rheumatology
☐ Cardiology	☐ Internal Med/Family Practice	☐ Other	☐ Surgery
☐ Gastroenterology	☐ Nephrology	☐ Otolaryngology	☐ Urology
☐ Genetics	☐ Neurology	☐ Pulmonary	☐ Wound Care

Site of Service

☐ SH Gerber	☐ SH Lemmen Holton (GR)	☐ SH Pennock	☐ SH United Memorial
☐ SH Helen DeVos (GR)	☐ SH Ludington	☐ SH Reed City	☐ SH Zeeland

Appointment Requests

☑ Infusion Appointment Request

Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Labs and infusion

Provider Reminder

☑ ONC PROVIDER REMINDER

Premedication is not required. Hypersensitivity reactions have occurred in patients who were premedicated. In clinical studies, reactions requiring treatment discontinuation included generalized erythema, rash, and urticaria. For symptoms of allergic reaction or anaphylaxis, order "Peds Hypersensitivity Reactions Therapy Plan".

Nursing Orders

☑ **Select Tocilizumab Medication Instructions Based On Route**

☐ ONC NURSING COMMUNICATION 1

Tocilizumab **(INTRAVENOUS)**

- Do not administer if the solution is discolored or if foreign particulate matter is present.
- Place intermittent infusion device as necessary.
- For intravenous route, obtain heart rate, respiratory rate, blood pressure, and pulse oximetry and assess for symptoms of anaphylaxis every 15 minutes during infusion through 30 minutes after infusion.
- Notify physician, NP or PA-C and stop infusion immediately if patient has itching, hives, swelling, fever, rigors, dyspnea, cough, or bronchospasm.
- Notify physician, NP or PA-C if greater than 20% decrease in systolic or diastolic blood pressure.
- Verify that patient has diphenhydramine/Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after infusion. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.
- At the end of IV infusion, flush secondary line with 0.9% Sodium Chloride.

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NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.

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☐ ONC NURSING COMMUNICATION 2

Tocilizumab **(SUBCUTANEOUS)**

- Do not administer if the solution is discolored or if foreign particulate matter is present.

- For subcutaneous administration, allow medication to reach room temperature prior to use. Rotate injection sites; avoid injecting into moles, scars, or tender, bruised, red, or hard skin.

- For subcutaneous route, obtain heart rate, respiratory rate, blood pressure, and pulse oximetry and assess for symptoms of anaphylaxis every 15 minutes through 30 minutes after injection.

- Notify physician, NP or PA-C if patient has itching, hives, swelling, fever, rigors, dyspnea, cough, or bronchospasm.

- Notify physician, NP or PA-C if greater than 20% decrease in systolic or diastolic blood pressure.

- Verify that patient has diphenhydramine/Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after injection. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.

Labs

	Interval	Duration
☐ Complete Blood Count w/Differential STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ Every ___ days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
☐ Comprehensive Metabolic Panel (CMP) STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ Every ___ days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
☐ Sedimentation rate STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ Every ___ days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
☐ Lipid Panel STAT, Starting S, For 1 Occurrences, Blood, Venous	☐ Every ___ days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments

Additional Lab Orders

	Interval	Duration
☐ _____	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments
☐ _____	☐ Every ___days ☐ Once	☐ Until date: _____ ☐ 1 year ☐ _____# of Treatments

Pre-Medications

☐ Pre-medication with dose: _____

☐ Pre-medication with dose: _____

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Patient Name

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Medications

☑ **Select Tocilizumab For Intravenous Or Subcutaneous Administration**

☐ tocilizumab (ACTEMRA) in sodium chloride 0.9 % IVPB

Dose:

☐ 4 mg/kg
☐ 8 mg/kg
☐ 10 mg/kg
☐ 12 mg/kg

Intravenous, Administer over 60 Minutes, Once, Starting S, For 1 Doses

Maximum dose is 800 mg.

Protect from light. Do NOT shake.
Use a dedicated IV line. Do not administer IV push or IV bolus.
Do not use if opaque particles or discoloration is visible.

☐ tocilizumab (ACTEMRA) subcutaneous prefilled syringe 162 mg

162 mg, Subcutaneous, Once, Starting S, For 1 Doses
Allow to reach room temperature prior to use. Rotate injection sites.

Telephone order/Verbal order documented and read-back completed. Practitioner's initials _____

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.

TRANSCRIBED:		**VALIDATED:**		**ORDERED:**			
TIME	**DATE**	**TIME**	**DATE**	**TIME**	**DATE**	Pager #	
	Sign		**R.N. Sign**		**Physician Print**		**Physician**

EPIC VERSION DATE: 03/27/20

