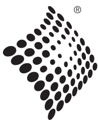

Spectrum Health

Physician's Orders TOCILIZUMAB (ACETMRA), ANTIRHEUMATIC DOSING - ADULT, OUTPATIENT, INFUSION CENTER

Page 1 to 2

Patient Name
DOB
MRN
Physician
FIN

Defaults for orders not otherwise specified below:
☐ Interval: Every 28 days
☐ Interval: Every ___ 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, Infusion and possible labs

Safety Parameters and Special Instructions

☑ ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 6
TOCILIZUMAB (ACTEMRA):

Tuberculosis surveillance and management: Screen prior to starting therapy and periodically during therapy. Treat latent infection prior to starting therapy.
Hepatitis B surveillance and management: Screen prior to initiating therapy. Refer to specialist as warranted by serology.

Prior to initiation obtain TB skin test, hepatitis B surface antigen (HBsAg) test, liver function test (LFT), lipids, complete blood count (CBC), up-to-date vaccinations, risk assessment for cancer, and pregnancy testing.

☑ ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 4
HEPATITIS B VIRUS SURVEILLANCE AND MAINTENANCE RECOMMENDATIONS: Screen **ONCE prior to treatment**. Refer to specialist as warranted by serology.

☑ ONC SAFETY PARAMETERS AND SPECIAL INSTRUCTIONS 5
TUBERCULOSIS SURVEILLANCE AND MANAGEMENT RECOMMENDATIONS: Screen prior to treatment and annually for continuing therapy. Treat latent infection prior to starting therapy.

Labs

	Interval	Duration
☑ Complete Blood Count w/Differential Status: Future, Expected: S, Expires: S+184, URGENT, Clinic Collect, Blood, Blood, Venous		
☑ Comprehensive Metabolic Panel (CMP) Status: Future, Expected: S, Expires: S+184, URGENT, Clinic Collect, Blood, Blood, Venous		
☑ Hepatic Function Panel (Liver Panel) Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous		
☑ Hepatitis B Surface Antigen Level Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous, Once	Once	
☑ Hepatitis B Core Total Antibody Level Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous, Once	Once	

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

CONTINUED ON PAGE 2 ➔

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

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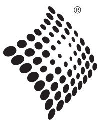

Spectrum Health

TOCILIZUMAB (ACETMRA), ANTIRHEUMATIC DOSING - ADULT, OUTPATIENT, INFUSION CENTER *(CONTINUED)*

Patient Name

DOB

MRN

Physician

FIN

Labs (continued)

	Interval	Duration
☑ **Arrange For Patient To Have Id Tb Skin Test Administered And Read Or Serum Tb Screening Lab Prior To Therapy Or Annually**		
☑ ONC PROVIDER REMINDER 28 Arrange for patient to have intradermal TB skin test (tuberculin PPD) screening performed and read **prior to initiating therapy and annually.**		
☐ TB Screen (Quantiferon Gold) Status: Future, Expected: S, Expires: S+365, URGENT, Clinic Collect, Blood, Blood, Venous, Once annually	Every 365 days	
☐ Lab: ______________________________________	☐ Every ___days ☐ Once	☐ Until date: _______ ☐ 1 year ☐ ______# of Treatments

Nursing Orders

☑ ONC NURSING COMMUNICATION 109

TOCILIZUMAB (ACTEMRA):

Monitor for hypersensitivity reactions. If patient reaction, stop immediately and contact provider. Treatment may need to be permanently discontinued.

Monitor patient for infection. Therapy should be interrupted until infection is controlled. Contact provider to discuss if patient has signs of infection.

An FDA-approved patient medication guide, which is available with the product information and at https://www.accessdata.fda.gov/drugsatfda_docs/label/2017/125276s114lbl.pdf#page=41, must be dispensed with this medication.

Educate patient about signs of a significant reaction (eg, wheezing; chest tightness; fever; itching; bad cough; blue skin color; seizures; or swelling of face, lips, tongue, or throat). Note: This is not a comprehensive list of all side effects. Patient should consult prescriber for additional questions.

☑ ONC NURSING COMMUNICATION 100

May Initiate IV Catheter Patency Adult Protocol

Treatment Parameters

☑ ONC MONITORING AND HOLD PARAMETERS 6

May proceed with therapy if absolute neutrophil count (ANC) greater than 2,000 per microliter

☑ ONC MONITORING AND HOLD PARAMETERS 7

May proceed with therapy if platelets greater than 100,000 per microliter

☑ ONC MONITORING AND HOLD PARAMETERS 8

May proceed with therapy if AST is less than 60 IU/L

☑ ONC MONITORING AND HOLD PARAMETERS 9

May proceed with therapy if ALT is less than 60 IU/L

☑ ONC MONITORING AND HOLD PARAMETERS 3

May proceed with treatment if hepatitis B core antibody and surface antigen labs have been resulted prior to the first dose, and the results are negative. **Once.**

☑ ONC MONITORING AND HOLD PARAMETERS 4

May proceed with treatment if tuberculosis screening test with either TB Screen blood test (QuantiFERON® Gold Plus) or TB skin test have been resulted prior to first dose and within one year for continuing therapy, and the results are negative. **Once annually.**

Medications

☑ tocilizumab (ACTEMRA) 4 mg/kg in sodium chloride 0.9 % 100 mL IVPB

4 mg/kg, Intravenous, Administer over 60 Minutes, Once, Starting S, For 1 Dose

Infuse over 60 minutes using a dedicated IV line. Do not infuse other agents through same IV line. Do not administer IV push or IV bolus. Do not use if opaque particles or discoloration is visible.

Confidentiality of this medical record shall be maintained except when use or disclosure is required or permitted by law, regulation, or written authorization by the patient.

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

EPIC VERSION DATE: 09/13/20

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