Edward-Elmhurst Cancer Centers
120 Spalding Drive; Suite 111; Naperville, IL 60540
Phone: 630/646-2273 Fax: 630/548-6617

24600 W. 127th Street; Plainfield, IL 60585
Phone: 630/646-2273 Fax: 630/548-6617

177 E. Brush Hill Road; Elmhurst, IL 60126
Phone: 630/646-2273 Fax: 331/221-3887

Actemra (TOCILIZUMAB) Standing Order

Patient Name: _____ DOB: _____

*****Please include current history and physical and any recent labs/tests, if applicable.*****

PLEASE ATTACH COPY OF INSURANCE CARD WITH THIS ORDER

Pre-Authorization # or Call Reference #: _____
(Ordering Physician Office is Responsible to Obtain Authorization/Referral)

Contact Name and Phone Number of Insurance Company: _____

If you have any questions regarding pre-authorizations, please contact (630) 527-3788 and ask for the billing department.

Allergies: _____

Diagnosis (ICD 10 Required): _____

Weight: Lbs: _____ Kg: _____

Actemra is indicated for treatment of adult patients with moderately to severely active RA who had an inadequate response to 1 or more TNF antagonist therapies. Recommended starting dose is 4mg/kg every 4 weeks, increasing to 8mg/kg every 4 weeks based on clinical response.

Pre-administration:

- ☐ Current TB skin test or chest x-ray
- ☐ ANC, Platelet count, Liver enzymes (ALT, AST) (Not recommended to start
- ☐ Actemra if ANC < 2000/mm3, platelets < 100,000/mm3 and liver enzymes > 1.5 times upper limit of normal)
- ☐ Pre-Infusion assessment to include BP, temp, pulse per unit protocol
- ☐ Post-infusion assessment to include BP, temp, pulse per unit protocol

Labs:

1. Please draw the following labs (please check):
   - ☐ CBC w/platelets and Auto Differential
   - ☐ Liver Enzymes
   - ☐ Other: _____

   Desired Frequency (please check):
   - ☐ Every 4 weeks done One week prior to infusion
   - ☐ Every 8 weeks done One week prior to infusion
   - ☐ Each Infusion
   - ☐ Other: _____

2. Please draw the following labs (please check):
   - ☐ Lipid Panel

☐ Other: _____

Desired Frequency (please check):

☐ One week prior to first infusion, then 4 weeks after treatment initiation, then every 6 months

☐ One week prior to first infusion, then 8 weeks after treatment initiation, then every 6 months

☐ 4 weeks after treatment initiation, then every 6 months

☐ Other: _____

Administration:

1. Dose: _____ mg/kg for _____ mg of Actemra every 4 weeks.
   Maximum dose is 800mg

2. Infuse 100ml Actemra solution over 60 minutes. Do not administer as bolus or push.
3. Do not administer Actemra during an active infection, including localized infections.

4. Interrupt Actemra:
   - ☐ If a serious infection develops, including localized infections
   - ☐ ANC 500-1000
   - ☐ Platelet count 50,000-100,000
   - ☐ Liver enzymes > 1 to 3X ULN after modification of DMARD dose (4mg/kg dose)
   - ☐ Liver Enzymes > 3 to 5X ULN

5. Discontinue Actemra:
   - ☐ ANC < 500
   - ☐ Platelets < 50,000
   - ☐ Liver enzymes > 5X ULN

6. Reduce Actemra dose from 8mg/kg to 4mg/kg:
   - ☐ Liver enzymes > 1 to 3X ULN after modification of DMARD dose

7. Do not administer Actemra concomitantly in the same line with other drugs. Avoid use of Actemra in combination with other biologic DMARDS.

8. Infusion reactions may include:

*Headache	*Hives/pruritis	*Hypertension
*Shortness of breath	*Backache	*Dizziness
*Nausea/vomiting	*Chest tightness	*Anaphylaxis

9. **In the event of a hypersensitivity reaction during the infusion of this medication, we will implement the reaction protocol. A designated nurse practitioner will evaluate your patient and your office will receive notification of the event.**

10. **In the event that your patient has a central line, it will be used per the Cancer Center protocol, unless otherwise directed.**

11. Premedicate with:

• Benadryl	_____ mg	PO or IV **(circle one)**	Yes ☐	No ☐
• Acetaminophen	_____ mg	PO	Yes ☐	No ☐

- Methylprednisolone 100mg IV Push — IV Push — Yes ☐ No ☐

12. Patient may be discharged post-infusion if stable. No monitoring time required.

Physician Signature: _____ **Date:** _____

Ordering Physician NPI: _____ **Edward Hospital NPI:** **1427069632**
Elmhurst Hospital NPI: **1548306343**

Physician Name (Please Print)	**Office Phone**	**Fax Number**

Revision/Review Date: 07/01/2021