Referral Status: ☐ New Patient ☐ Updated Patient Information

CMC Infusion Center- Referral Face Sheet

Patient Name: _____ Patient D.O.B._____/_____/_____

Patient Phone # (_____) _____-_____ Gender_____

Patient Address _____

City_____ State _____ Zip Code_____

Referring Provider (Please Print) _____

Office Phone # (_____) _____-_____ Office Contact: _____

Office Fax # (_____) _____-_____

If referring provider and/or patient is external to Conway Medical Center. Please include:

- Most recent history and physical including:
  - Comprehensive medication list
  - Past medical history
  - Related past/ failed therapies (with dates)
  - Known allergies
- Most recent labs / test result (Ex. CBC, PPD, Hepatitis screening, etc.)
- Insurance Information

Please fax requested documentation, face sheet, and treatment plan to **843-234-5460** attention CMC Medication Management Specialist. Please feel free to call 843-234-8575 with any questions.

We look forward to the opportunity to be a part of your patient's treatment journey at Conway Medical Center.

Referral Status ☐ New ☐ Order Change ☐ Order Renewal

Actemra® (tocilizumab) Treatment Plan

Patient Name: _____ **Patient DOB** _____/_____/_____

General

☐ Diagnosis- Rheumatoid Arthritis Seropositive multiple sites ICD-10 Code _____

☐ Diagnosis- Rheumatoid Arthritis Seronegative multiple sites ICD-10 Code _____

☐ Diagnosis- Giant cell arteritis ICD-10 Code _____

Pt. Weight _____ Pt Height _____ Known Allergies _____

Requested Start Date ____/____/_____ Requested Frequency: Every 4 weeks

Has patient previously received this medication ☐ No ☐ Yes, if so, date of last infusion ____/____/_____

Authorized Treatment Duration ☐ 12 Months ☐ Other _____

***Note: Pharmacy will interchange biosimilar product per insurance approval. If interchange is NOT allowed by provider, please indicate preferred product here:

Preferred Product: _____

☑ Vital Signs (Month 1 to 12) BP/HR/Resp/SpO2/Temp
Baseline on arrival to unit, upon completion of therapy, and prior to discharge

Tylenol (Month 1 to 12)

☐ *650 mg, Oral, Tab, Day of Tx*
Comments: Administer 30 minutes before tocilizumab dose

Benadryl (Month 1 to 12)

☐ *25 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before tocilizumab dose

☐ *50 mg, IV Push, Injection, Day of Tx*
Comments: Administer 30 minutes before tocilizumab dose

SOLU-Medrol (Month 1 to 12)

☐ *40 mg, IV Push, Powder-Inj, Day of Tx*
Comments: Administer 30 minutes before tocilizumab dose

Actemra (Month 1 to 12)

☐ *4 mg/kg, IV Piggyback, Injection*
Comments: infuse in 100 mL 0.9% NaCl over 60 minutes. Nurse to slowly flush tubing with up to 20 mL 0.9% NS once infusion is finished to clear all medication in IV tubing. Max dose = 800 mg

☐ *8 mg/kg, IV Piggyback, Injection,*
Comments: infuse in 100 mL 0.9% NaCl over 60 minutes. Nurse to slowly flush tubing with up to 20 mL 0.9% NS once infusion is finished to clear all medication in IV tubing. Max dose = 800 mg

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____/_____/_____

Actemra® (tocilizumab) Treatment Plan

☑ Communication Order (Month 1 to 12)
Patient must stay in infusion area for 30 min post infusion. If vital signs normal may be discharged to home. If abnormal, call physician. Patient should be accompanied by another adult upon discharge

☑ Communication Order (Month 1 to 12)
Ensure the CBC with diff is available within 2 months of initiation or within 3 months of subsequent infusions of tocilizumab (Actemra). Notify provider if labs are not within defined parameters: Note Defined Parameters=: absolute neutrophil count (ANC) of 2000/mm3 or greater; platelet count of 100,000/mm3 or greater are required before initiating tocilizumab (Actemra)

☑ Communication Order (Month 1 to 12)
*Ensure AST/ALT results are available within 2 months of initiation or within 3 months of subsequent infusions. Notify provider if results outside of normal limits: Note: Do **not** initiate tocilizumab in patients with baseline ALT or AST levels greater than 1.5 x ULN*

☑ Communication Order (Month 1 to 12)
Ensure negative PPD or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ Notify Provider (Month 1 to 12)
for fever/chills, chest pain, hypotension, hypertension, dyspnea, Pruritis, urticaria, persistent flushing, Temperature > 100, or HR <50 or > 130

☑ Notify Provider (Month 1 to 12)
For POSITIVE results of PPD test or other test to exclude latent tuberculosis. Results must be within the last 12 months.

☑ INF Infusion Room Orders Subphase (Month 1 to 12)

Labs (Month 1 to 12) Duration: 12 Months

☑ QuantiFERON TB Gold Plus (if needed)

☑ CBC w/ Diff (Month 1 to 12)
Blood, Routine, (if needed)

☑ AST (Month 1 to 12)
Blood, Routine, (if needed)

☑ ALT (Month 1 to 12)
Blood, Routine, (if needed)

Prescriber Signature (No Stamped Signatures or Electronic Signatures)

Provider Signature _____ Provider Name (please print)_____

Date_____/_____/_____ Patient Name _____ Patient DOB_____/_____/_____