Northern Light Health

☐ NL Infusion Care, AR Gould, **Presque Isle**
Phone: 207-768-4589; Fax: 207-768-4183
☐ NL Infusion Care, **Blue Hill**
Phone: 207-374-3995; Fax: 207-374-3970
☐ NL Infusion Care, CA Dean, **Greenville**
Phone: 207-695-5222; Fax: 207-695-4801
☐ NL Infusion Care, **Brewer**
Phone: 207-973-9785; Fax: 207-973-9788
☐ NL Mary Dow Center, **Ellsworth**
Phone: 207-664-5584; Fax: 207-664-5485
☐ NL Infusion Care, Mayo, **Dover-Foxcroft**
Phone: 207-564-4254; Fax: 207-564-4418
☐ NL Mercy Cancer Care, **Portland**
Phone: 207-553-6868; Fax: 207-904-0917
☐ NL Infusion Care, SVH, **Pittsfield**
Phone: 207-487-4052; Fax: 207-487-3995

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

OP tocilizumab Adult (Paper)

Diagnosis ☐ Rheumatoid Arthritis ICD 10: M06.69 ☐ Giant Cell Arteritis ICD 10: M31
☐ Other _____

Tuberculosis (TB) and Hepatitis B Testing
Testing is required prior to initiation of therapy, a change in living environment, or travel to an area that would pose an increased risk of TB/Hepatitis

Quantiferon TB Gold Test: Date: _____/_____/_____ Result: _____
T SPOT: Date: _____/_____/_____ Result: _____
Hepatitis B: Date: _____/_____/_____ Result: _____
Hepatitis C: Date: _____/_____/_____ Result: _____

Patient Care
☒ Saline Lock
Insert peripheral Saline Lock, discontinue after therapy complete. May leave in for 5 consecutive treatment days
☐ Access PICC Line
☐ Remove PICC Line ONLY after verifying regimen is complete with provider
☐ Access Port-a-Cath
☐ Access Central Access Device (Hickman, Triple lumen)

Restoration of Patency for PICC/Port-a-cath
☒ alteplase
2 mg, ONCE, Catheter Clearance, If initial dose is ineffective after 2 hours, repeat dose. Notify provider if second dose is ineffective. Total Max dose = 2 doses

Laboratory
Labs required prior to each tocilizumab infusion
☒ Wait for lab results before infusing tocilizumab, if not done within the last 7 days.
☒ CBC with Differential *BLOOD, Expedite, Pre-Procedure, Duration _____ Months*
☒ Alanine Aminotransferase [ALT] *BLOOD, Expedite, Pre-Procedure, Duration _____ Months*
☒ Aspartate Aminotransferase [AST] *BLOOD, Expedite, Pre-Procedure, Duration _____ Months*

Premedication
☐ acetaminophen (Tylenol) *650 mg, PO, ONCE*
☐ cetirizine (Zyrtec) *10 mg, PO, ONCE*
☐ famotidine (Pepcid) *20 mg, PO, ONCE*
☐ methylprednisolone *40 mg, Soln, IVP, ONCE*
☐ methylprednisolone *125 mg, Soln, IVP, ONCE*
☐ methylprednisolone _____ *mg, Soln, IVP, ONCE*

Other_____
_____
_____

Date: _____ Time: _____
Provider Signature: _____ Print Name: _____
Phone: _____ Fax: _____
Pharmacy Signature: _____

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PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

OP tocilizumab Adult (Paper)

Height: _____ cm **Weight:** _____ kg

TREATMENT PARAMETERS:
Initial Treatment, Treat if:
ANC greater than or equal to: 2,000/mm(3);
Platelets greater than or equal to: 100,000/mm(3);
ALT/AST: less than: 1.5 times the upper limit of normal
**Please reference specific lab's range, as it varies. For most Northern Light Health locations values are ALT: 90 IU/L, AST: 50 IU/L

Subsequent Treatments, Treat if: **Note:** Metrics should be checked in the frequency at which labs are ordered**.**
ANC greater than: 1,000/mm(3);
Platelets greater than: 100,000/mm(3)
ALT/AST: Greater than 1 to 3 times ULN (ALT 180 IU/L, AST 100 IU/L) = **Contact Provider**
ALT/AST: Greater than 3 to 5 times ULN (ALT 300 IU/L, AST 167 IU/L) = **Hold Treatment**

Medication
Pharmacist can substitute infusion medication based on patient insurance coverage or NLH preferred biosimilar unless provider orders a specific brand, to include written rationale

Medication to be rounded by pharmacist to nearest 40 mg for patients greater than 60 kg. For patient 60 kg or less, rounded to the nearest 10 mg

☐ tocilizumab
___ *mg/kg =* ___ *mg/100 mL 0.9% Sodium Chloride, IVPB, Infuse over 60 minutes minimum*
Brand of tocilizumab (to be completed by pharmacy once prior authorization complete): _____

Treatment Schedule:
Subsequent dosing: ☐ Every ___ weeks

Duration: ☐ *6 months* ☐ *1 year*

Pharmacy to dispense specific brand (include rationale for needing specific brand): _____

Anaphylaxis Treatment
☒ epinephrine (EpiPen Auto Injector) *0.3 mg, Kit, IM, Every 5 Minute Interval, PRN, airway swelling, difficulty breathing, Indication: hypotension (systolic blood pressure less than 90). Max total dose = 0.9 mg (3 doses). May be given concurrently with diphenhydramine, famotidine and methylprednisolone based on indications*
☒ diphenhydramine (Benadryl) *50 mg, Soln, IV Push, ONCE, PRN, Indication: itching, hives, difficulty breathing or swelling of the face, lips and throat. May be given concurrently with epinephrine, famotidine and methylprednisolone based on indications*
☒ famotidine (Pepcid) *20 mg, Soln, IV Push, ONCE, PRN, Indication: angioedema, stomach upset. May be given concurrently with epinephrine, diphenhydramine and methylprednisolone based on indications*
☒ methylprednisolone (SOLU-Medrol) *125 mg, Soln, IV Push, ONCE, PRN, Indication: prevention of biphasic reaction, inflamed airway. May be given concurrently with epinephrine, diphenhydramine and famotidine based on indications*
☒ albuterol (Proventil NEB) *2.5 mg, Soln, NEB, ONCE, PRN, Indication: bronchospasm*
☒ oxygen *via: Nasal Cannula PRN Low oxygen saturation, Maintain saturation 90% or greater, wean as tolerated*

Date: _____ Time: _____
Provider Signature: _____ Print Name: _____
Phone: _____ Fax: _____
Pharmacy Signature: _____