Northern Light Health

☐ Northern Light Infusion Center, Brewer
Phone: (207) 973-9785 **Fax:** (207) 973-9788

☐ Northern Light Maine Coast, Mary Dow Infusion Center
Phone: (207) 664-5584 **Fax:** (207) 664-5485

PATIENT IDENTIFICATION
Known allergies / medication sensitivities:

OP tocilizumab Adult (Paper)

Diagnosis: ☐ Rheumatoid Arthritis
☐ Other: _____ **ICD10:** _____

Hepatitis and Tuberculosis Serologies Completed: ***Note:** *If NO, treatment will not be scheduled until results are available.*

Hepatitis B: Yes ☐ No ☐ Date: ____/____/____ Result: _____
Hepatitis C: Yes ☐ No ☐ Date: ____/____/____ Result: _____
Quantiferon TB Gold Test OR T SPOT: Date: ____/____/____ Which test: _____ Result: _____

IV Access:

☐ Saline Lock:
- ☑ Insert peripheral Saline Lock; *may leave in for consecutive treatment days*
- ☑ Discontinue Saline Lock after therapy completed

☐ PICC Line:
- ☑ Routine PICC Line Care, labs and restoration (Refer to Policy #26.802 & #26.807)
- ☐ Discontinue PICC Line (verify regimen is complete with provider prior to removing line)

☐ Porta cath / Central Access Device (Hickman, Triple lumen):
- ☑ Porta cath access, labs, restoration and de-access (Refer to Policy #26.902) / Central Access Device use and care (Refer to Policy #26.102)

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

TREATMENT PARAMETERS:

Initial Treatment, Treat if:	***Subsequent Treatments, Treat if:***	
ANC greater than or equal to: 2,000	ANC greater than: 1,000	ALT/AST: Greater than 1 to 3 times ULN = **Contact Provider**
Platelets greater than or equal to: 100,000	Platelets greater than: 100,000	ALT/AST: Greater than 3 to 5 times ULN = **Hold Treatment**
ALT/AST: less than: 1.5 times ULN		

Laboratory:

☐ Wait for lab results before infusing tocilizumab
☐ CBC with Differential *BLOOD, Expedite, Pre-Procedure, Duration _____ Months, Prior to each tocilizumab infusion*
☐ Alanine Aminotransferase [ALT] *BLOOD, Expedite, Pre-Procedure, Duration _____ Months, Prior to each tocilizumab infusion*
☐ Aspartate Aminotransferase [AST] *BLOOD, Expedite, Pre-Procedure, Duration _____ Months, Prior to each tocilizumab infusion*

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*

Medication: ***Note:** *Specify a specific brand or biosimilar, if medically indicated. If not, the preferred brand or biosimilar will be used.*

☑ Tocilizumab *mg/kg =* ____ *mg/100 mL 0.9% Sodium Chloride, IVPB, Infuse over 60 minutes minimum*
☐ **Repeat** *every* _____ *weeks*; **Duration:** ☐ *6 months* ☐ *1 year* ☐ *Other*: _____

Other: _____

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

PROVIDERS MUST EXERCISE INDEPENDENT CLINICAL JUDGMENT WHEN USING ORDER SETS
January 2025