

☐ 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)

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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:

ANC greater than or equal to: 2,000

Platelets greater than or equal to: 100,000

ALT/AST: less than: 1.5 times ULN

Subsequent Treatments, Treat if:

ANC greater than: 1,000

Platelets greater than: 100,000

ALT/AST: Greater than 1 to 3 times ULN = **Contact Provider**

ALT/AST: Greater than 3 to 5 times ULN = **Hold Treatment**

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

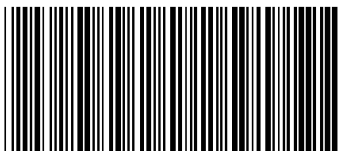
☐ methylPREDNISolone 125 mg, Soln, IVP, ONCE

☐ 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