

Actemra (Tocilizumab) Infusion OrderPatient Name: _____ DOB: _____ ☐ Male ☐ Female

Diagnosis (please provide ICD10 code) _____

☐ Other: _____☐ NKDA Allergies: _____☐ New Start Therapy☐ Continuation of Therapy

Date of last dose (if applicable): _____

Ordering Provider: _____

Provider NPI: _____

Phone: _____

Fax: _____

Practice Address: _____

City: _____

State: _____

Zip Code: _____

PRE-MEDICATION

- ☐ Acetaminophen 1000mg PO ☐ Solu-Medrol 125mg IVP
☐ Diphenhydramine 25mg PO ☐ Solu-Cortef 100mg IVP
☐ Ceterizine 10mg PO ☐ Diphenhydramine 25mg IVP

REQUIRED LABS

- ☒ TB status and date (please attach results):

☒ Hepatitis B status & date (please attach results):

ACTEMRA ORDERS**DOSING:**

- ☒ Mix in 100ml 0.9% sodium chloride and administer intravenous infusion over 1 hour

Dose: ☐ 4mg/kg ☐ 8mg/kg ☐ 10mg/kg ☐ Other: _____ Pt weight: _____**FREQUENCY:**

- ☐ Every 2 weeks
☐ Every 4 weeks
☐ Other: _____

REFILLS:☐ _____

*(if not indicated prescription will expire one year
from date signed)*

Noble Infusion Standing Orders:

- ☒ Provide treatment under Noble Infusion's Clinical Guidelines, Medication Safety Protocol, Emergency Guidelines, and Action Plan for Infusion Reactions.

Provider Name_____
Provider Signature_____
Date