NATIONWIDE CHILDREN'S
When your child needs a hospital, everything matters.℠

PATIENT IDENTIFICATION

ACTEMRA (Tocilizumab) REFERRAL FORM

NCH Homecare Infusion Pharmacy
Telephone: 614-355-1100 Fax: 614-355-1182

Section 1: Patient Information

Patient name (Last, First): _____ MRN_____ Sex (circle one) M / F

DOB: _____ Weight: _____on (date) ___/___/_____ Allergies: _____

Diagnosis:_____

ICD10 Code:_____

Initiate therapy in home between (dates): ___/___/_____ to ___/___/_____

TB status:
☐ PPD (-) date_____ ☐ Active TB
☐ Quantiferon (-) date_____
☐ Last CXR date:_____ ☐ Unknown
If (+) TB, treatment course taken: _____

Section 2: Ordering Information (must be signed by physician only)

Pre-Medications: (Oral medications to be supplied by family)
Administer 30 minutes prior to infusion (if not given by family at home prior to visit)
☐ Acetaminophen PO x1: ☐325mg ☐500mg ☐650mg ☐10mg/kg (max 650 mg)
☐ Diphenhydramine PO x1: ☐12.5mg ☐25mg ☐ 50mg ☐ Other_____

Prn Medications: (Oral medications to be supplied by family)
☐ Ondansetron (Zofran) PO q8 hours prn nausea pre- and post- infusion ☐4mg ☐8mg
☐ Ibuprofen PO q6 hours prn pain/headache ☐400 mg ☐ 600mg ☐ Other_____

Infusion Medication:
☐ Actemra (Tocilizumab)- available in 400mg, 200mg, and 80mg vials: May dispense doses to nearest vial size (+/- 10%)
Dose: _____ mg/dose (max: 1000 mg/dose) = _____mg/kg/dose Dose to be further diluted in NS prior to IV administration.
Infuse IV every _____ weeks (over 60 minutes) via Infusion Pump. Refill: _____ doses (or max of 6 months)
☐ Other IV medications_____

Catheter Care: Line type: ☐ Peripheral line ☐ Implanted port ☐ PICC ☐ Broviac ☐ Other: _____
☐ Lidocaine 4% Cream (L-M-X) 30 gm tube. Apply as directed and as needed prior to peripheral or implanted port access.
☐ 0.9% NaCl: Flush line with 10ml for implanted ports or 3-5 ml for other IV lines before and after Actemra and as needed.
☐ Heparin 100 units/ml: Flush line with 2ml after infusion for CVC and with 3ml after infusion for implanted ports.

Administration Orders:
1. Assess patient for any signs of acute illness (ie: fever, cough, flu-like symptoms…) if present, call the on-call Rheumatologist to determine if the infusion should be rescheduled.
2. Start peripheral IV or access central line prior to Actemra infusion.
3. Monitor vital signs (temperature, pulse, respirations, and blood pressure) prior to Actemra infusion, after start of infusion, and after end of infusion.
4. Homecare to follow up with Rheumatology service via email (preferred) or fax at the completion of the infusion to confirm infusion given and tolerated **or** in the event that patient misses doses and/or scheduled visit.

Emergency Management:
1. Homecare RN must stop the infusion in the event of an infusion reaction, regardless if the reaction is mild or severe. If reaction is mild, **1st** page the ordering Rheumatologist (pager**=** ___-___-____), **2nd** (if no response after 5min) call the Physician Direct Connect line (877-355-0221) to page on-call doctor, and **3rd** page Section Chiefs Dr. Stacy Ardoin (pager 614-346-6791) or Dr. Sharon Bout-Tabaku (614-690-0079). The doctor will instruct the RN which, if any, emergency medications to give.
2. If the patient has an anaphylactic reaction the RN must stop the infusion and call 911. If the reaction is life-threatening, the RN should administer Epinephrine per dosing below. After patient is stable, or EMT has arrived, call Rheumatologist on call.
   ** It is important to note that the strongest indicator of an impending infusion reaction is the patient's general sense of dysphoria**
3. Call the MD on call through PCTC and ask for the doctor to be paged for an "urgent infusion reaction" for:
   a. Temp greater than 38C
   b. HR greater than 110bpm or less than 50bpm
   c. RR greater than 32/min or less than 12/min
   d. Diastolic BP greater than 95mmHg or less than 55mmHg
4. Other:_____

MEDICATIONS TO HAVE READILY AVAILABLE (to be given by infusion nurse in the event of signs/symptoms of an anaphylactic reaction)
☐ Epinephrine 1:1000 (1 mg/mL) ampule #1 Sig: If wt ≥ 30 kg, Inject 0.3 mg (0.3 mL) IM x 1, If wt < 30 kg, Inject 0.01 mg/kg IM x 1
☐ Diphenhydramine 50 mg/1 mL vial # 1 Sig: Inject 25 mg (or 1 mg/kg if < 25 kg) IVP over 3 minutes x 1
☐ Methylprednisolone SS [Solu-MEDROL] 40 mg/1 mL act-o-vial #1 Sig: Inject 40 mg IVP (or 1 mg/kg if <40 kg) over 3 minutes x 1

Labs: ☐ CBC w/diff q___ weeks ☐ ESR/CRP q___ weeks ☐ Complete Metabolic panel q___ weeks ☐ Urinalysis q___weeks
☐ Hepatic function panel q___weeks ☐ AST/ALT q___ weeks ☐ Lipid panel q___ weeks
☐ Other _____
Ordering Physician (print): _____ (signature): _____
Date/Time: _____ Rheumatology Clinic Main Campus, 700 Children's Drive, Columbus, OH 43205 Phone: (614)722-5525