KAISER PERMANENTE®

Name: _____

Kaiser Permanente Member I.D. # _____

Date of Birth _____

# Tocilizumab (ACTEMRA)
## Infusion Therapy Plan Orders



**Instructions to Provider**

*Review orders and note any changes. All orders with ☑ will be placed unless otherwise noted. Please fax completed order form to the infusion center where the patient will be receiving treatment (see fax numbers at the end of this protocol). Lab orders are not included on this form – place orders via usual method. Lab monitoring is the responsibility of the ordering physician.*

***Please complete all of the following:***

☐ **Pre-Service Authorization** has been obtained by Kaiser Permanente **Fax:** 1-888-282-2685 **Voice**: 1-800-289-1363

**Order Date**: _____

**Weight:** _____kg

**Diagnosis:**

ICD-10 code *(REQUIRED):* _____

ICD-10 description_____

### General Plan Communication

- Special instructions/notes: _____

### Provider Information

- Screen for viral hepatitis prior to use; anti-rheumatic therapy may cause reactivation of hepatitis B
- Ensure baseline PPD or quantiFERON-TB assay for latent TB
- Live vaccines should not be given concurrently or within 3 months of discontinuation of therapy
- Do not combine with tumor necrosis factor (TNF) agents or other biologic DMARDs.
- Patient requires monitoring of CBC w/diff and AST/ALT every 4 weeks prior to each treatment.
- Review lipid panel 4 and 8 weeks after initiation, then every 6 months.

### Infusion Therapy

☑ **tocilizumab (ACTEMRA) in 0.9% sodium chloride 100 mL IV infusion**

***Dose:*** ☑ **4 mg/kg x weight (kg) = Total Dose _____ mg**

☐ 8 mg/kg x weight (kg) = Total Dose _____ mg

*Route:* Intravenous

*Frequency:* **Once every 4 weeks**

*Infuse over:* 60 minutes

*If infusion-related reaction:*

1) STOP infusion immediately; 2) Increase primary infusion to wide open rate; 3) Administer PRN medications per hypersensitivity protocol; 4) Notify MD

***Note any changes to above regimen:*** _____

### Pre-Meds

☐ acetaminophen (TYLENOL) tablet

*Dose:* 650 mg *Route:* Oral *Frequency:* Once, 30 minutes prior to tocilizumab infusion.

May also be given once as needed during infusion for achiness, headache, or fever if not given prior to infusion.

☐ cetirizine (ZYRTEC) tablet

*Dose:* 10 mg *Route:* Oral *Frequency:* Once, 30 minutes prior to tocilizumab infusion.

*Frequency:* Once, at least 30 minutes prior to tocilizumab infusion (if not taken at home).

☐ hydrocortisone sodium succinate (SOLU-CORTEF) injectable [not routine; only if breakthrough reaction]

*Dose:* 50 mg *Route:* Oral *Frequency:* Once, 30 minutes prior to tocilizumab infusion in addition to acetaminophen and antihistamine if patient still experiences symptoms with acetaminophen and antihistamine alone.

☐ Other: _____

*Dose:* _____ *Route:* Oral *Frequency:* Once, 30 minutes prior to tocilizumab infusion

☑ No routine pre-medications necessary. Above medications may be given if patient has reaction and requires pre-medications for future doses.

**Provider Signature:** _____ **Date:** _____

**Printed Name:** _____ **Phone:** _____ **Fax:** _____

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### IV Line Care

☑ 0.9% sodium chloride infusion 250 mL
*Rate:* 30 mL/hr *Route:* Intravenous *Frequency:* Run continuously to keep vein open
Start peripheral IV if no central line

☑ heparin flush 100 unit/mL
*Dose:* 500 units *Route:* Intracatheter *Frequency:* PRN for IV line care per Nursing Policy

### Infusion Reaction Meds

☑ albuterol (PROVENTIL) nebulizer solution 0.083%
*Dose:* 2.5 mg *Route:* Nebulization *Frequency:* PRN for shortness of breath/wheezing

☑ diphenhydrAMINE (BENADRYL) injectable
*Dose:* 25 mg *Route:* Intravenous *Frequency:* Once PRN, May repeat x1 for urticaria, pruritus, shortness of breath. May repeat in 15 minutes if symptoms not resolved.

☑ EPINEPHrine (EpiPen) 0.3 mg/0.3 mL IM Auto-Injector
*Dose:* 0.3 mg *Route:* Intramuscular *Frequency:* Once PRN for anaphylaxis. Inject into lateral thigh and hold for 10 seconds. Massage the injected area. Use for patients weighing greater than 27.3 kg (60 lbs). Use amp and 1.5 inch needle for patients with BMI greater than 30. Notify physician if administered.

☑ hydrocortisone sodium succinate (SOLU-CORTEF) injectable
*Dose:* 100 mg *Route:* Intravenous *Frequency:* Once PRN for hypersensitivity

### Lab Review for Nursing

Continue with infusion only if patient meets the following criteria:

- ANC greater than or equal to 2,000 (first dose) or greater than or equal to 1,000 (subsequent doses)
- Platelets greater than or equal to 100,000
- AST/ALT less than 1.5 x ULN
- Verify lipid panel drawn at 4 and 8 weeks after initial treatment.
- If lipid panel labs not drawn prior to treatment, instruct patient to have labs drawn and notify provider, but proceed with infusion.

### Nursing Orders

- *Initial dose only:* Verify PPD or quantiFERON-TB assay for latent TB results are negative for TB. Do not infuse tocilizumab without negative TB results.
- Do not administer tocilizumab and notify provider if patient has a temperature greater than 100 degrees F, complains of symptoms of acute viral or bacterial illness, or if patient is taking antibiotics for current infection.
- Discontinue IV line when therapy complete and patient stabilized.

### References


- ACTEMRA® (tocilizumab) Injection, for intravenous infusion prescribing information.


### Kaiser Permanente Infusion Locations

**Bellevue Medical Center**
*11511 NE 10th St, Bellevue, WA 98004*
**Fax: 425-502-3512 Phone: 425-502-3510**

**Capitol Hill Medical Center**
*201 16th Ave E, Seattle WA 98112*
**Fax: 206-326-2104 Phone: 206-326-3109**

**Everett Medical Center**
*2930 Maple St, Everett, WA 98201*
**Fax: 425-261-1578 Phone: 425-261-1566**

**Olympia Medical Center**
*700 Lilly Road N.E., Olympia, WA 98506*
**Fax: 360-923-7106 Phone: 360-923-7164**

**Riverfront Medical Center – Spokane**
*W 322 North River Drive, Spokane, WA 99201*
**Fax: 509-324-7168 Phone: 509-241-2073**

**Silverdale Medical Center**
*10452 Silverdale Way NW, Silverdale, WA 98383*
**Fax: 360-307-7421 Phone: 360-307-7316**

**Tacoma Medical Center**
*209 Martin Luther King Jr Way, Tacoma, WA 98405*
**Fax: 253-383-6262 Phone: 253-596-3666**

**Provider Signature:** _____ **Date:** _____

**Printed Name:** _____ **Phone:** _____ **Fax:** _____