KAISER PERMANENTE®

Name: _____

Kaiser Permanente Member I.D. # _____

Date of Birth _____ ___

Tocilizumab
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

- Biosimilar tocilizumab-aazg (Tyenne) is the preferred and defaulted agent in this plan
- 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-aazg (TYENNE) 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-aazg 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-aazg infusion

Frequency: Once, at least 30 minutes prior to tocilizumab-aazg 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-aazg 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-aazg 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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Infusion Therapy Plan Orders

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

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

☑ MethylPREDNISolone Sod Succ (PF) Inj 125 mg (SOLU-Medrol PF).
Dose : 125 mg *Route* : IV push *Frequency:* Once PRN for hypersensitivity reaction. Notify MD upon giving medication

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-aazg without negative TB results
- Do not administer tocilizumab-aazg and notify provider if patient has a temperature greater than 100º 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

- TYENNE® (tocilizumab-aazg) 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:** _____