INFUSION CENTER OF NEW ENGLAND

Checklist for Actemra (tocilizumab) Referral

Patient Name: _____ **DOB:** _____ **Date:** _____

Referring Physician: _____ **NPI:**_____

Office Contact/Title/Email: _____

Office Address: _____

Office Phone: _____ **Office Fax:** _____

Best contact number for physician in case of reaction: _____

Please return completed checklist and checklist items to initiate referral. Use this form as fax cover sheet.

- ☐ Patient demographic information
- ☐ Insurance information and copy of insurance card/s (front and back). *Include primary and secondary insurance
- ☐ Supporting clinical notes and office visits. Two notes preferred.
  - Note should include any therapies tried/failed, and must include discussion about Actemra
  - Medication list and allergies
- ☐ Supporting lab reports/imaging for Actemra treatment
  - Baseline: Lipid panel, LFTs, neutrophils, platelets, and negative TB screening
  - *Recommended*: negative hepatitis B screening
  - For continued therapy:
    - Lipid panel 4-8 weeks after Actemra start
    - LFTs every 4-8 weeks for first 6 months after Actemra start, then every 3 months thereafter
    - Neutrophils and platelets 4-8 weeks after Actemra start, then every 3 months thereafter
- ☐ Actemra Prescribing Order (see attached)

-- We will obtain prior authorization and schedule your patient as soon as possible --

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Fax all information to our Infusion Coordinator: 508-698-8671

Call with any questions: 781-551-5812 option 4

Visit our website: www.InfusionCenterNE.com
Email: info@infusioncenterne.com

Infusion Center of New England
9 Payson Road, Suite 100, Foxboro MA 02035
Ph: 781-551-5812
Fax: 508-698-8671

Prescribing Order: Actemra (tocilizumab)

Date of Order: _____ ☐ New Start ☐ Maintenance
Date of last infusion: _____

Patient Name: _____ **DOB:** _____ **M/F:** ____

Diagnosis (include ICD-10 code/s):_____

☐ **NKDA** **Allergies:** _____

Patient Weight: _____

Premedication:

☐ Acetaminophen 1000mg PO
☐ Loratadine 10mg or Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ Diphenhydramine 25mg IV
☐ Solu-medrol 125mg IV
☐ Other: _____

Lab Orders:

☐ CBC w/diff, CMP every _____ weeks
☐ LFTs every _____ weeks
☐ Lipid Panel 4-8 weeks after treatment start x 1
☐ Other: _____

Actemra Medication Order

Dosing: ☐ 4mg/kg ☐ 8mg/kg ☐ Other: _____

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

Administration:

- ✓ Mix Actemra in 100ml Normal Saline and administer intravenously over 1 hour.
- ✓ Do not administer if patient has active signs or symptoms of infection.
- ✓ HOLD Actemra if most recent ANC < 2000, AST/ALT > 1.5x normal limit, or platelets <100,000. Notify physician.
- ✓ In case of infusion reaction, STOP infusion and follow NCNE infusion reaction protocol. Notify physician.

Ordering Provider Name **NPI**

Signature **Date**

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