



Phone: 608-690-7210
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www.mysmartinfusion.com

Location

- Eau Claire Weston
- Middleton Onalaska

Actemra (Tocilizumab)
And Biosimilars
Infusion/Subcutaneous Injection Order Form

Patient Information

Patient Name: _____ DOB: _____ M F

Allergies: _____

New Treatment Continuing Treatment Last Treatment Date: _____ Next Due Date: _____

Diagnosis and ICD 10 Code (Required)

- Rheumatoid Arthritis Unspecified ICD 10 Code: M06.9
- Rheumatoid Arthritis Rheumatoid Arthritis with Rheumatoid Factor, Unspecified ICD 10 Code: M05.9

Required Labs

- TB/QuantIFERON Negative on _____**
- May proceed with infusion with additional testing every ____ years
- No follow up testing necessary

Hepatitis B Status & Date: _____

Most Recent CBC, CMP & Lipid Panel (attach results)

Pre-Medication Orders

- Acetaminophen (Tylenol) 500mg 650mg 1000mg PO
- Diphenhydramine (Benadryl) 25mg 50mg PO IV
- Methylprednisolone (Solu-Medrol) 125mg IV
- Ondansetron (Zofran) 4mg PO IV
- Other: _____ Route: _____

Dose: _____ **Frequency:** _____

Adverse Reaction Management & Nursing Orders	
Full protocols are available for review at mysmartinfusion.com or upon request.	
<input checked="" type="checkbox"/> Administer the following emergency medications per Smart Infusion Therapy Services protocol: <input checked="" type="checkbox"/> Acetaminophen 650mg PO, <input checked="" type="checkbox"/> Diphenhydramine 25mg-50mg PO or IV <input checked="" type="checkbox"/> Ondansetron 4mg IV <input checked="" type="checkbox"/> Sodium Chloride 0.9% 1000mL IV <input checked="" type="checkbox"/> Methylprednisolone 125mg IV <input checked="" type="checkbox"/> Albuterol Sulfate 2.5mg nebulized <input checked="" type="checkbox"/> Oxygen 1-6LPM continuous flow <input checked="" type="checkbox"/> Epinephrine 0.3mg/0.3mL IM	<input checked="" type="checkbox"/> Manage VAD per protocol: <input checked="" type="checkbox"/> Start/Access and Discontinue PIV/CVC <input checked="" type="checkbox"/> Flush with NS and/or Heparin per protocol based on line type <input checked="" type="checkbox"/> Other: _____
<input type="checkbox"/> Other: _____	

<p>Actemra Medication Order Refill x12 months unless otherwise noted: _____ Patient Weight: _____ KG</p> <ul style="list-style-type: none"><input type="checkbox"/> Actemra (tocilizumab)<input type="checkbox"/> Tyenne (tocilizumab-aazg)<input type="checkbox"/> Avtozma (tocilizumab-anoh) <p>Will substitute Actemra (tocilizumab) for biosimilar or referenced product based on insurance and availability. OR</p> <p><input type="checkbox"/> Dispense as Written</p> <p>Infusion <u>Dosage</u> <input type="checkbox"/> 4mg/kg IV <input type="checkbox"/> 8mg/kg IV <input type="checkbox"/> 10mg/kg IV <input type="checkbox"/> 12mg/kg IV <input type="checkbox"/> Other _____</p> <p><u>Frequency</u> <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> Other _____</p> <p>Subcutaneous Injection <u>Dosage</u> <input type="checkbox"/> 162mg <input type="checkbox"/> Other _____</p> <p><u>Frequency</u> <input type="checkbox"/> Weekly <input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 3 weeks <input type="checkbox"/> Other _____</p>
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<p>Required Documents</p> <ul style="list-style-type: none"><input type="checkbox"/> Patient Demographic Sheet<input type="checkbox"/> H & P within the past 6 months<input type="checkbox"/> Current Medication List<input type="checkbox"/> Clinical & Progress Notes (including last infusion note)<input type="checkbox"/> Copy of Insurance Card (Front/Back)

Provider Information

Provider Name: _____ Provider NPI: _____

Office Phone: _____ Office Fax: _____

Provider Signature: _____ Date: _____