BIG SKY IV CARE
Infusion Pharmacy & Nursing
An Access Infusion Care Company

ACTEMRA (TOCILIZUMAB) ORDERS

PATIENT INFORMATION

Name: _____ DOB: _____ Height: _____ Weight: _____

Address: _____ Phone: _____ Allergies: _____

City, State, Zip: _____ Email: _____

REFERRAL STATUS

☐ New Referral ☐ Dose or Frequency Change ☐ Order Renewal

Is this the first dose? ☐ Yes ☐ No, date of last infusion: _____ Line type: ☐ PIV ☐ PICC ☐ Port ☐ Other

DIAGNOSIS AND ICD-10 CODE

☐ Rheumatoid Arthritis ICD-10 Code: _____

☐ Systemic Juvenile Idiopathic Arthritis (SJIA) ICD-10 Code: _____

☐ Polyarticular Juvenile Idiopathic Arthritis (PJIA) ICD-10 Code: _____

☐ Other: _____ ICD-10 Code: _____

REQUIRED DOCUMENTATION

☐ This signed order form by the provider

☐ Patient demographics AND insurance information

☐ TB Test Results

☐ H&P and Clinical/Progress notes supporting primary diagnosis

☐ Labs and Tests supporting primary diagnosis

List Tried & Failed Therapies, including duration of treatment:

1)
2)
3)

MEDICATION ORDERS

☐ Actrema 4mg/kg IV over 60 minutes every 4 weeks

☐ Actemra 8mg/kg IV over 60 minutes every 4 weeks

Note that doses >800mg for rheumatoid arthritis are not recommended.

☐ Actemra 162mg SubQ every week

☐ Actemra 162mg SubQ every 2 weeks

☐ Actemra 162mg SubQ every ____ weeks

** Dose may be rounded to nearest vial size within +/-10%. TO PROHIBIT dose rounding check here ☐

Refills: ☐ X 6 months ☐ X 1 Year ☐ Other: _____

■ RN to manage VAD per company protocol and administer ordered therapy per manufacturer guideline

■ RN to access/start and deaccess/discontinue VAD as appropriate for therapy administration

■ RN to flush and lock VAD/CVAD per company protocol

Other: _____

PREMEDICATION ORDERS

☐ Acetaminophen 650mg PO prior to infusion

☐ Diphenhydramine 25mg PO prior to infusion

☐ Other: _____

☐ Other: _____

EMERGENCY MEDICATIONS

■ Administer the following medications as needed for infusion-related reactions per company protocol:

Adults (weight >40kg):

Diphenhydramine 25mg-50mg PO
Diphenhydramine 25mg-50mg slow IV push over 2-5 mins
Acetaminophen 325mg-650mg PO
Methylprednisolone 125mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.3mg IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Pediatrics (weight <40kg): (may adjust with weight changes)

Diphenhydramine 25mg PO
Diphenhydramine 25mg slow IV push over 2-5 mins
Acetaminophen 325mg PO
Methylprednisolone 40mg slow IV push over at least 5 mins as tolerated
Epinephrine 0.15mg (<30kg) or 0.3mg (>30kg) IM/SQ, may repeat x1
Sodium chloride 0.9% 500ml over 30-60 mins, may repeat x1 if hypotensive

Oxygen 1-6LPM continuous flow per nasal cannula or face mask, titrate to maintain SpO2 of 95-100% (AIC/AIS only)

PRESCRIBER INFORMATION

Prescriber Name: _____ NPI Number: _____

Office Phone: _____ Office Fax: _____

Prescriber Signature: _____ Date: _____

REV: 6/2025

Helena, MT
Phone: (406) 430-1265
Fax: (406) 752-0443

Kalispell, MT
Phone: (406) 752-0440
Fax: (406) 752-0443