NEW ENGLAND
Cancer Specialists
Infusion Center
Kennebunk · Portsmouth · Scarborough · Topsham
Phone: 207-303-3225 Fax:207-692-2473

Tocilizumab (Actemra) Order Form – J9362

Patient Name:_____ **DOB:**_____

Diagnosis: _____ Diagnosis Code:_____

Height: _____(cm) Actual Weight: ____(kg) Allergies: _____

Please list any premeds needed here:_____

_____

****Required labs: Latest TB screening prior to therapy, lipid panel, CBC and CMP prior to therapy, 4 to 8 weeks after start and every 3 months thereafter.**

Dosing Rheumatoid Arthritis:

☐ **Tocilizumab 4 mg/kg IV q 4 weeks: Total dose_____mg.**

Available vial sizes are 400mg, 200mg and 80mg. Please round to appropriate vial size.

Orders valid through___/___/____

☐ **Tocilizumab 8 mg/kg IV q 4 weeks: Total dose_____mg.**

Orders valid through___/___/____

☐ **Tocilizumab (SQ) 162 mg SQ every OTHER week (<100kg)**

Orders valid through___/___/____

☐ **Tocilizumab (SQ) 162 mg EVERY week (>=100kg)**

Orders valid through___/___/____

Dosing Giant Cell Arteritis(GCA):

☐ **Tocilizumab (SQ) 162 mg SQ every OTHER week (<100kg)**

Orders valid through___/___/____

☐ **Tocilizumab (SQ) 162 mg EVERY week (>=100kg)**

Orders valid through___/___/____

* **In the event of a hypersensitivity reaction, patients will be treated according to NECS protocols for the management of infusion-room drug reactions.**

Provider Name: _____

Provider Signature: _____ Date: _____

Phone: _____ Fax: _____ Pager: _____