NEW ENGLAND
Cancer Specialists

Infusion Center

KENNEBUNK | ROCK ROW | TOPSHAM | PORTSMOUTH
PHONE: (207) 303-3225 | FAX: (207) 692-2473

Tocilizumab (Actemra) Order Form–J9362

Patient Name | Middle | Last | DOB

Diagnosis | Diagnosis Code

Height (cm) | Actual Weight (kg) | Allergies

Please list any premeds needed.

*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 400 mg, 200 mg and 80 mg. 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