Physician's Orders
TOCILIZUMAB - PEDIATRIC, OUTPATIENT, INFUSION CENTER
Page 1 of 3

 Defaults for orders not otherwise specified below:

- Interval: Every 7 days
- Interval: Every 14 days
- Interval: Every 21 days

Duration:
- Until date: __________
- 1 year
- _______ # of Treatments

Anticipated Infusion Date________ ICD 10 Code with Description________________________

Height_____________(cm) Weight___________(kg) Allergies____________________________________

Provider Specialty

- Allergy/Immunology
- Infectious Disease
- OB/GYN
- Rheumatology
- Cardiology
- Internal Med/Family Practice
- Other
- Surgery
- Gastroenterology
- Nephrology
- Otolaryngology
- Urology
- Genetics
- Neurology
- Pulmonary
- Wound Care

Site of Service

- SH Gerber
- SH Lemmen Holton (GR)
- SH Pennock
- SH United Memorial
- SH Helen DeVos (GR)
- SH Ludington
- SH Reed City
- SH Zeeland

Appointment Requests

- Infusion Appointment Request
  Status: Future, Expected: S, Expires: S+365, Sched. Tolerance: Schedule appointment at most 3 days before or at most 3 days after, Labs and infusion

Provider Reminder

- ONC PROVIDER REMINDER
  Premedication is not required. Hypersensitivity reactions have occurred in patients who were premedicated. In clinical studies, reactions requiring treatment discontinuation included generalized erythema, rash, and urticaria. For symptoms of allergic reaction or anaphylaxis, order “Peds Hypersensitivity Reactions Therapy Plan”.

Nursing Orders

- Select Tocilizumab Medication Instructions Based On Route
  - ONC NURSING COMMUNICATION 1

  Tocilizumab (INTRAVENOUS)
  - Do not administer if the solution is discolored or if foreign particulate matter is present.
  - Place intermittent infusion device as necessary.
  - For intravenous route, obtain heart rate, respiratory rate, blood pressure, and pulse oximetry and assess for symptoms of anaphylaxis every 15 minutes during infusion through 30 minutes after infusion.
  - Notify physician, NP or PA C and stop infusion immediately if patient has itching, hives, swelling, fever, rigors, dyspnea, cough, or bronchospasm.
  - Notify physician, NP or PA-C if greater than 20% decrease in systolic or diastolic blood pressure.
  - Verify that patient has diphenhydramine/Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after infusion. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.
  - At the end of IV infusion, flush secondary line with 0.9% Sodium Chloride.

CONTINUED ON PAGE 2 ➔

NOTE: Epic Treatment/Therapy Plan Orders. To be scanned/attached to the appropriate Infusion Referral Order in Epic.
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- Notify physician, NP or PA-C if patient has itching, hives, swelling, fever, rigors, dyspnea, cough, or bronchospasm.
- Notify physician, NP or PA-C if greater than 20% decrease in systolic or diastolic blood pressure.
- Verify that patient has diphenhydramine/Epi-pen available (as appropriate) for immediate home use. Advise patient that severe hypersensitivity or anaphylactic reactions may occur during and after injection. Inform patients of signs and symptoms of anaphylaxis and hypersensitivity reactions, and importance of seeking medical care.

### Labs

<table>
<thead>
<tr>
<th>Test</th>
<th>Interval</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete Blood Count w/Differential</td>
<td>Every ___ days</td>
<td>Until date: _______</td>
</tr>
<tr>
<td></td>
<td>Once</td>
<td>______# of Treatments</td>
</tr>
<tr>
<td>Comprehensive Metabolic Panel (CMP)</td>
<td>Every ___ days</td>
<td>Until date: _______</td>
</tr>
<tr>
<td></td>
<td>Once</td>
<td>______# of Treatments</td>
</tr>
<tr>
<td>Sedimentation rate</td>
<td>Every ___ days</td>
<td>Until date: _______</td>
</tr>
<tr>
<td></td>
<td>Once</td>
<td>______# of Treatments</td>
</tr>
<tr>
<td>Lipid Panel</td>
<td>Every ___ days</td>
<td>Until date: _______</td>
</tr>
<tr>
<td></td>
<td>Once</td>
<td>______# of Treatments</td>
</tr>
</tbody>
</table>

### Additional Lab Orders

<table>
<thead>
<tr>
<th>Test</th>
<th>Interval</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Every ___ days</td>
<td>Until date: _______</td>
</tr>
<tr>
<td></td>
<td>Once</td>
<td>______# of Treatments</td>
</tr>
</tbody>
</table>

### Pre-Medications

- Pre-medication with dose: ____________________________________________________________
- Pre-medication with dose: ____________________________________________________________
TOCILIZUMAB - PEDIATRIC, OUTPATIENT, INFUSION CENTER (CONTINUED)

Medications

☐ Select Tocilizumab For Intravenous Or Subcutaneous Administration

☐ tocilizumab (ACTEMRA) in sodium chloride 0.9 % IVPB
  Dose:
  ☐ 4 mg/kg
  ☐ 8 mg/kg
  ☐ 10 mg/kg
  ☐ 12 mg/kg

  Intravenous, Administer over 60 Minutes, Once, Starting S, For 1 Doses
  Maximum dose is 800 mg.
  Protect from light. Do NOT shake.
  Use a dedicated IV line. Do not administer IV push or IV bolus.
  Do not use if opaque particles or discoloration is visible.

☐ tocilizumab (ACTEMRA) subcutaneous prefilled syringe 162 mg

  162 mg, Subcutaneous, Once, Starting S, For 1 Doses
  Allow to reach room temperature prior to use. Rotate injection sites.

DONE

Telephone order/Verbal order documented and read-back completed. Practitioner’s initials __________

NOTE: Unless Order is written DAW (dispense as written), medication may be supplied which is a generic equivalent by nonproprietary name.