**PATIENT INFORMATION\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Referral Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Desired Treatment Start Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Height: Weight(kg): Pt Contact #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Diagnosis (select one/complete remaining ICD-10 Digits as needed):**

* M05.\_\_\_ Rheumatoid Arthritis with Rheumatoid factor
* M06.\_\_\_ Rheumatoid Arthritis without Rheumatoid factor
* Other: Clinical Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD-10 Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medication/Nursing Care Orders (select all that apply):**

* Tocilizumab (Actemra) in 100 mL Sodium Chloride 0.9%, IV, to infuse over 1 hour
	+ Induction: 4mg/kg and then maintenance dose of

 \_\_ 4mg/kg or \_\_\_ 8mg/kg every \_\_\_ weeks

* + Maintenance: \_\_\_4mg/kg \_\_\_\_ 8mg/kg every \_\_\_\_ weeks
* Round up to nearest whole vial
* Give exact dose
* Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_ Rate: \_\_\_\_\_\_\_\_\_\_\_\_\_
* Order Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Completion Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* PICC line in place-Insertion Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* PICC Dressing Change Weekly on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Remove PICC on the last day of treatment? Yes No

**Pre-Treatment Medications to be administered 30 minutes prior to treatment (Check/Complete all that apply):**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Acetaminophen
 | * 500mg
 | * 650mg
 | * 1000mg
 | * PO
 |
| * Diphenhydramine
 | * 25mg
 | * 50mg
 | * PO
 | * IV
 |
| * Methylprednisolone
 | * 40mg
 | * 125mg
 | * IV
 |  |
| * Famotidine
 | * 20mg
 | * PO
 | * IV
 |  |
| * Other:
 |

**Pre-Treatment Requirements (Check if completed. Provide supporting documentation if outside of Billings Clinic Provider Group):**

* TB screening results (PPD or QuantiFERON Gold Test) prior to start of therapy and within last 12 months.
* Lipids, Liver Function Tests, Neutrophils, Platelets

**Standing Orders:**

* Reaction management protocol initiation for hypersensitivity/ anaphylactic reaction.

BBC Emergent Management of Anaphylaxis in Adults #PHY037 version 05/15/21

* Laboratory monitoring required due to potential consequences of treatment-related changes in neutrophils, platelets, lipids, and liver function tests.
* Perform test for latent TB; if positive, start treatment for TB prior to starting ACTEMRA. Monitor all patients for active TB during treatment, even if initial latent TB test is negative.
* ACTEMRA should not be initiated in patients with an absolute neutrophil count (ANC) below 2000 mm3, platelet count below 100,000 mm3, or who have ALT or AST above 1.5 times the upper limit of normal (ULN).
* If ANC = 500-1000 cells/mm3, interrupt tocilizumab dosing and resume when ANC is greater than 1000 cells/mm3. Resume at 4mg/kg and increase as clinically appropriate. If ANC < 500 cells/mm3, discontinue and notify referring physician.
* If platelet count = 50,000-100,000 cells/mm3, interrupt tocilizumab and resume at 4 mg/kg when platelet count >100,000 cells/mm3. May increase as clinically appropriate. If platelet count < 50,000 cells/mm3, discontinue tocilizumab and notify referring physician.
* If liver enzymes are >3-5 times the upper limit of normal (ULN), hold tocilizumab and notify physician.
* If cholesterol level is elevated, notify physician for monitoring.

**Laboratory Orders (Check all that apply);**

* **TB screening-**Prior to therapy initiation
* **Lipid**s-Prior to therapy then 4-8 weeks following initiation.
* **Liver Function Tests** – Prior to therapy, 4-8 weeks following initiation for the first 6 months of treatment; then at 3-month intervals.
* **Neutrophils**-Prior to therapy, 4-8 weeks following initiation; then at 3-month intervals.
* **Platelets**-Prior to therapy, 4-8 weeks following initiation; then at 3-month intervals.
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Interval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Orders/Plan of Care Instructions:**

|  |
| --- |
|  |

**PROVIDER INFORMATION**

Referring Practice:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone/Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name (Print):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **Fax completed treatment plan to:** **Beartooth Billings Clinic Outpatient Services** **Fax:406-815-6667** **Phone: 406-446-0563 or 406-446-0565****IF OUTSIDE OF BILLINGS CLINIC PROVIDER GROUP:****Please include patient demographics/insurance information, current medication list, lab/test results as applicable and most recent provider documentation related to prescribed treatment plan.**  |

* Our team will confirm receipt of referral to the contact listed above.
* Treatment documentation will be viewable in Cerner if within Billings Clinic Provider Group, faxed upon completion to all other referring providers.
* Change in patient’s baseline status and/or initiation of reaction protocol will be immediately reported to the referring provider.
* If collecting lab series, please provide preferred means for relaying results and/or desired parameters required to proceed and/or withhold treatment. If not specified, treatment will be either held or given as directed based on current ***Wolters Kluwer/Up To Date*** administration guidelines.

***Thank you for allowing us to participate in your patient’s care-***

**Beartooth Billings Outpatient Services.**