VANCOUVER CLINIC® **ADULT AMBULATORY NON-CHEMO INFUSION REFERAL and ORDER** Attn: Infusion Department **Tocilizumab (ACTEMRA®)**	**NAME:** **DOB:** **INSURANCE:** **PROVIDER NAME:** **CLINIC NAME and Phone number:**

Weight:_____lb/kg Height:_____inch/cm
Diagnostic Code ICD-10:_____ Diagnosis:_____

□ Initial Consult □ Annual Renewal
Treatment Start Date: _____

****These orders will expire after 365 days; new orders are needed after the expiration date****

This form serves as a referral to infusion services and for medication ordering.
Patients will be seen by our internal infusion clinician for purposes of providing care.

GUIDELINES FOR ORDERING:

- Send FACE SHEET and H&P, relevant labs and/or most recent chart note
- Vancouver Clinic infusion service will initiate Adverse Reaction Algorithm per our service protocol.
- Pre-medication(s) based on protocol (if needed)
- If pre-screening test and labs are not accessible through Epic, please fax a copy of request lab as well (see below). Otherwise, authorized Vancouver Clinic infusion clinician to order the lab.
- Patient must be able to ambulate independently (if patient needs assistance with restrooming, a personal caregiver or capable family member must accompany and remain with patient for the duration of the appointment).

PRE-SCREENING/LAB:

- CBC with differential
- AST/ALT
- Lipid panel
- Hepatitis B surface antigen and core antibody total
- Tuberculin test (PPD or QuantiFERON Gold blood test). If result is indeterminate, a follow up chest X-ray must be performed to rule out TB.

MEDICATIONS:

Tocilizumab (ACTEMRA®) _____ mg/kg = _____ mg in sodium chloride 0.9% 100 mL intravenous, over 60 minutes. Doses will be rounded to nearest vial size. The recommended starting dose is 4 mg/kg every 4 weeks followed by an increase to 8 mg/kg every 4 weeks based on clinical response. Max dose: 800mg

Interval: (must check one)

- ☐ Every _____ weeks
- ☐ Once

Please fax the completed form and pertinent information to Fax: 360-604-1776

Vancouver Clinic Outpatient Infusion Service *- 700 NE 87th Ave Suite 330, Vancouver, WA 98664*
Phone: 360-541-3245

VANCOUVER CLINIC® **ADULT AMBULATORY NON-CHEMO INFUSION REFERAL and ORDER** Attn: Infusion Department **Tocilizumab (ACTEMRA®)**	**NAME:** **DOB:** **INSURANCE:** **PROVIDER NAME:** **CLINIC NAME and Phone number:**

Provider's signature: _____

Provider's printed name: _____ **Date:** _____

Please fax the completed form and pertinent information to Fax: 360-604-1776

Vancouver Clinic Outpatient Infusion Service *- 700 NE 87th Ave Suite 330, Vancouver, WA 98664*
Phone: 360-541-3245