Novella Infusion

Patient Name:
DOB:
Date of Last Infusion
Insurance:

Clinic Location:
Merrimack, NH ☐
Concord, NH ☐

Tocilizumab (Actemra®) Infusion Orders

Diagnosis (please provide ICD-10 code in space provided): **Weight:** _____

_____ Rheumatoid Arthritis (ICD-10)

_____ Giant Cell Arteritis (ICD-10)

_____ Cytokine Release Syndrome (ICD-10)

_____ Other: _____ (ICD-10)

Nursing:

- Hold infusion and notify provider for:
  - Signs or symptoms of illness or active infection
  - Planned/recent surgical procedures
  - New onset abdominal pain or jaundice
  - Neurological changes
  - *Live* vaccines
  - ANC less than or equal to 1000 mm^3
  - PLT less than or equal to 100,000 mm^3
  - AST or ALT greater than 1.5x ULN
- If infusion-related reaction occurs, stop infusion, notify provider and follow Hypersensitivity Reaction Management Protocol as clinically indicated.

Dose:

Administer _____ mg/kg tocilizumab in 100 mL 0.9% sodium chloride over 60 minutes.
Unless prohibited by provider, may round by up to 10% to nearest available vial sizes.

Frequency (chose one):

☐ Every 4 weeks ☐ Every _____ weeks

Additional Orders:

Provider name (print): _____ Date:_____

Provider signature: _____ Time: _____