Holland Hospital

AMBULATORY TREATMENT UNIT

Ambulatory Treatment Unit
Phone (616) 394-3547
Fax (616) 394-2139

Actemra Order Set

☐ = Optional Order ● = Routine Order (Cross out and initial **BULLETED ORDERS** that do not apply)

ORDERS

Date: _____ **Time:** _____ **ICD 10 Code:** _____

Diagnosis: ☐ _____ ☐ Rheumatoid arthritis ☐ Giant Cell Arteritis

Patient Name: _____ **Date of Birth:** _____ **Weight:** _____ (kg)

Allergies: _____

☑ **Last TB Test Date** _____ **TB Test Result** _____ **Initial TB Test required prior to first dose. Any subsequent testing optional, and to be ordered and evaluated by provider. Nurse to confirm negative test. If positive, nurse will hold therapy and contact provider.*

PRE-MEDICATIONS - When ordering a pretreatment medication, please select appropriate formulation.

- ☐ Acetaminophen - *650 mg, Oral: Tab. Give prior to treatment.*
- ☐ diphenhydramine - *25 mg oral capsule - 25 mg, Oral: Cap, Give prior to treatment.*
- ☐ Methylprednisolone (Solu-Medrol) - *40 mg, IV Push. Give prior to treatment.*
- ☐ Other _____

Tocilizumab (Actemra) Dosing

- ☐ 4 mg/kg (Not to exceed 800 mg) every 4 weeks infused over 1 hour
- ☐ 6 mg/kg (Not to exceed 600 mg) every 4 weeks infused over 1 hour
- ☐ 8 mg/kg (Not to exceed 800 mg) every 4 weeks infused over 1 hour
- ☐ Other _____

Labs Orders _____

_____

_____

NURSING CONSIDERATIONS

- Do not administer Actemra in patients with active or suspected infection

Treatment for Adverse Drug Reactions (for mild to moderate infusion reaction)

- Slow or stop infusion for 20 minutes
- Give:
  - Diphenhydramine (Benadryl) 25 mg slow IVP STAT (may repeat times 1)
  - Acetaminophen (Tylenol) 650 mg PO STAT, if not already given as a "premedication". (Maximum acetaminophen doses of 4000 mg in 24 hours from all combined sources.)
  - Methylprednisolone (Solu-Medrol) 125 mg IVP STAT
- Place O_2 PRN at 4 – 6 liters per nasal cannula STAT
- Vital signs with PO_2 every 5 minutes until stable
- Notify the physician of reaction. Request further orders as indicated.
- Complete adverse drug reaction PowerForm and document in the allergy profile for all drug reactions.

By signing this document, the provider confirms that:

- Patient is not on any other biological disease-modifying anti-rheumatic drugs (DMARDs) such as TNF antagonists, IL-1R antagonists, anti-CD20 monoclonal antibodies and selective co-stimulation modulators due to possibility of increased immunosuppression leading to increased risk of infection
- Patient either is not pregnant or understands the potential for Actemra to cause fetal harm if pregnant
- That ordering provider is responsible for baseline ANC, platelet and AST/ALT/Liver monitoring to ensure patient eligible for Actemra administration.

Provider Signature: _____ Date: _____

Provider Name and Credentials (please print): _____ Time: _____

Office Phone: _____ Office Fax: _____