BioPlus® Infusion

Fax your completed order to 877-734-1157

Patient Name: _____ DOB: ___/___/_____

Date of Last Infusion: ___/___/_____ Height _____ Weight _____

Infusion Location: (state and site) _____

Actemra® (tocilizumab) Infusion Orders

Diagnosis: please add the ICD=10 code

☐ Rheumatoid Arthritis	☐ Giant Cell Artieritis
☐ Cytokine Release Syndrome	☐ Systemic Sclerosis Interstitial Lung Disease
☐ OTHER: _____	

- Hold infusion and notify provider for:
  - Signs or symptoms of illness or active infection
  - Planned/recent surgical procedures or recent live vaccines
  - New abdominal pain, fatigue, anorexia, dark urine, jaundice or neurological changes
  - For Initial therapy: ANC at least 2000mm3
  - For continuation therapy: ANC at least 1000mm3
  - PLT at least 100,000 mm^3
  - AST or ALT no greater than 1.5 times normal level
- Measure and record weight at each appointment

Lab orders:

☐ CBC w/diff, AST, ALT at Week 4, then every 3 months ☐ Lipid Panel at Week 4, then every 6 months

☐ Other: _____

Administer Tocilizumab	Current Weight: _____ kg
☐ RA/ CRS: 4mg/kg (_____ kg) = _____ mg (Max dose should not exceed 800mg per infusion)	
☐ RA /CRS: 8mg/kg (_____ kg)= _____ mg (Max dose should not exceed 800mg per infusion)	
☐ GCA: 6mg/kg (_____ kg)= _____ mg (Max dose should not exceed 600mg per infusion)	
☐ Other: _____ (Max dose should not exceed 800mg per infusion)	
Mix in 100ml of 0.9% NS and administer over 60mins	
• If infusion-related reaction occurs, stop infusion & follow Hypersensitivity Reaction Management Protocol	

Frequency (chose one)

☐ Every 4 weeks

☐ Every _____ weeks

Provider Name (print): _____ Date: _____

Provider Signature: _____ Time: _____

Reviewed 1/30/25. Order valid for one year unless otherwise indicated. IV solutions/diluents may be substituted as allowed per manufacturer's instructions as necessitated by product availability.