

ACTEMRA

Please include the following to expedite the order:
Patient Demographics, Insurance Information, Labs

PATIENT INFORMATION

Referral Status: ☐ New Referral ☐ Updated Order ☐ Order Renewal

Patient Name: _____ DOB: _____ Gender: ☐ M ☐ F ☐ Other _____

Phone: _____ Address: _____ City: _____ State: _____ Zip: _____

PRESCRIBER INFORMATION

Prescriber Name: _____ DEA: _____ NPI: _____ State License: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

CLINICAL INFORMATION

Diagnosis: ☐ M05.____ (Rheumatoid Arthritis w/ RF) ☐ M06.____ (Rheumatoid Arthritis w/o RF)
☐ M31.____ (Giant Cell Arteritis) ☐ D89.____ (Cytokine Release Syndrome) ☐ Other: _____

Allergies: _____ Weight: _____ ☐ Kg ☐ Lbs Height: _____ ☐ cm ☐ in

TB/PPD test: ☐ Positive ☐ Negative HBV: ☐ Yes ☐ No If yes, treated: ☐ Yes ☐ No

TREATMENT INFORMATION

ACTEMRA (tocilizumab)

Route: Intravenous infusion

Dose: ☐ 4mg/kg ☐ 6mg/kg ☐ 8mg/kg
☐ Other: _____ mg/kg

Frequency:

☐ Every four weeks

☐ Every _____ weeks

Quantity: _____ Refills: _____

Premedication Protocol:

☐ Diphenhydramine: ☐ 25mg ☐ 50mg ☐ PO ☐ IV

☐ Acetaminophen: ☐ 325mg ☐ 500mg ☐ 650mg PO

☐ Other: _____

Sig: _____

Special Instructions: _____

Provider Name: _____ Provider Signature: _____ Date: _____

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