

(tocilizumab)

ACTEMRA infusion orders

Date: _____

Patient Name _____ DOB _____

Phone _____ M ☐ F ☐

☐ Allergies _____

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

REFERRAL STATUS

New Prescription

Order Renewal

Does or Frequency Change

Discontinuation

DIAGNOSIS Please provide ICD-10 code

- | | |
|--|--|
| ☐ _____ Rheumatoid Arthritis (RA) | ☐ _____ Cytokine Release Syndrome (CRS) |
| ☐ _____ Giant Cell Arthritis (GCA) | ☐ _____ (other) |
| ☐ _____ Polyarticular Idiopathic Arthritis in > 2yro (PJIA) | |
| ☐ _____ Systemic Juvenile Idiopathic Arthritis (SJIA) | |

PRE-MEDICATION

- | | |
|--|---|
| ☐ Tylenol 1000mg PO | ☐ Solu-Medrol 125mg IVP |
| ☐ Cetirizine 10mg PO | ☐ Solu-Cortef 100mg IVP |
| ☐ Diphenhydramine 25mg PO | ☐ Diphenhydramine 25mg IVP |
| ☐ _____ | ☐ _____ (other) |

ACTEMRA ORDERS

DOSAGE

- ☐ Initial dose of 4mg/kg every 4 weeks, then 8mg/kg every 4 weeks (induction)
- ☐ 4mg/kg every 4 weeks
- ☐ 8mg/kg every 4 weeks
- ☐ Other _____

PATIENT WEIGHT

_____ lbs.

_____ kg

NOTES ☐ Total dosages: _____ Route: ☐ SQ ☐ IV
☐ 1yr ☐ Other _____ ☐ # of Refills _____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____