TN
100 Covey Drive
Suite 307
Franklin, TN 37067

ThrIVewell INFUSION
Office: 212-803-3339 Fax : 646-768-8600

REJUVEINATE

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

PRE-MEDICATION

☐ Tylenol 1000mg PO
☐ Cetirizine 10mg PO
☐ Diphenhydramine 25mg PO
☐ _____
☐ Solu-Medrol 125mg IVP
☐ Solu-Cortef 100mg IVP
☐ 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: ○ 1yr ○ Other _____ Route: ○ SQ ○ IV ○ # of Refills _____

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____