☐ *Borough Park*
1428 36th Street
Suite 107
Brooklyn, NY 11218

☐ *Crown Heights*
555 Lefferts Avenue
Brooklyn, NY 11225

☐ *Manhattan*
57W 57Street
Suite 601
New York, NY 10019

☐ *Manhasset*
333 East Shore Road
Suite 201
Manhasset, NY 11030

☐ *Rockville Centre*
165 North Village Avenue
Suite 133
Rockville Center, NY 11570

☐ *Elmsford/ Terrytown*
555 Taxter Road
3rd Floor
Elmsford, NY 10523

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

Mission Medical

☐ *Manhattan*
225 E 70th Street
Suite 1E
New York, NY 10021

☐ *Queens*
64-05 Yellowstone Blvd
CF104
Forest Hills, NY 11375

☐ *Manhattan*
225 East 70th Street
New York, NY 10021

☐ *Holbrook/ Ronkonkoma*
233 Union Ave
Suite 207
Holbrook, NY 11741

☐ *Scarsdale*
495 Central Park Avenue
Suite 205
Scarsdale, NY 10583

☐ *5 Towns*
141 Washington Avenue
Cedarhurst, NY 11559

☐ *Long Beach*
917 Beech Street
Long Beach, NY 11561

☐ *Riverhead*
1228 E Main Street
Suite A
Riverhead, NY 11901

(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 _____