

Boca Raton  
9980 Central Park Blvd  
Suite 202, N  
Boca Raton, FL 33428



(tocilizumab)

# ACTEMRA

Infusion orders

Date: \_\_\_\_\_

PATIENT INFORMATION		
Name:	DOB:	SEX: M <input type="checkbox"/> F <input type="checkbox"/>
ICD-10 code (required):	ICD-10 description:	
<input type="checkbox"/> NKDA Allergies:	Weight lbs/kg:	

REFERRAL STATUS	
<input type="checkbox"/> New Referral	<input type="checkbox"/> Referral Renewal
<input type="checkbox"/> Medication/Order Change	<input type="checkbox"/> Benefits Verification Only
<input type="checkbox"/> Discontinuation Order	

PHYSICIAN INFORMATION	
Referral Coordinator Name:	Referral Coordinator Email:
Ordering Provider:	Provider NPI:
Referring Practice Name:	Phone: _____ Fax: _____
Practice Address:	City: _____ State: _____ Zip Code: _____

**DIAGNOSIS** *Please provide ICD-10 code*

- \_\_\_\_\_ Rheumatoid Arthritis (RA)
- \_\_\_\_\_ Giant Cell Arthritis (GCA)
- \_\_\_\_\_ Polyarticular Idiopathic Arthritis in > 2yro (PJIA)
- \_\_\_\_\_ Systemic Juvenile Idiopathic Arthritis (SJIA)

**PRE-MEDICATION**

<input type="checkbox"/> Tylenol 1000mg PO	<input type="checkbox"/> Solu-Medrol 125mg IVP
<input type="checkbox"/> Diphenhydramine 25mg PO	<input type="checkbox"/> Solu-Cortef 100mg IVP
<input type="checkbox"/> Cetirizine 10mg PO	<input type="checkbox"/> Diphenhydramine 25mg IVP
<input type="checkbox"/> _____ (other)	<input type="checkbox"/> _____ (other)

**SPECIAL INSTRUCTIONS**

**ACTEMRA ORDERS**

**DOSE:**

- Initial dose of 4mg/kg every 4 weeks, then 8mg/kg every 4 weeks
- 4mg/kg every 4 weeks
- 8mg/kg every 4 weeks
- Other \_\_\_\_\_

**PATIENT WEIGHT**

\_\_\_\_\_ lbs.  
\_\_\_\_\_ kg

**TOTAL DOSES:**

1 yr \_\_\_\_\_  Other \_\_\_\_\_  Refill \_\_\_\_\_

Route:  SQ  IV

**NOTES/ADDITIONAL COMMENTS:**

## ORDERING PROVIDER

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Provider \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_