

# ACTEMRA (TOCILUZUMAB) ORDER FORM

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Mobile Number: \_\_\_\_\_ Patient Weight: \_\_\_\_\_

Allergies: \_\_\_\_\_

## DIAGNOSIS (Provider must specify)

Rheumatoid Arthritis, ICD 10: M05. \_\_\_\_\_ or M06. \_\_\_\_\_

Giant Cell Arteritis, ICD 10: M31. \_\_\_\_\_

Other: \_\_\_\_\_

## PROVIDER INFORMATION

Provider Name (print name): \_\_\_\_\_ Provider NPI: \_\_\_\_\_

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

Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email Address: \_\_\_\_\_

**Prerequisites to treatment** – ensure the following information is complete and attached with referral:

- Demographics     Labs and tests supporting diagnosis     Office/progress notes

## PRE-MEDICATION (Not typically indicated)

Acetaminophen (Tylenol) 500 mg PO     Famotidine 20 mg IV     Methylprednisolone (Solu-Medrol) 125 mg IVP

Benadryl 25mg PO     Cetirizine (Zyrtec) 10 mg PO

Other: \_\_\_\_\_ Dose: \_\_\_\_\_ Route: \_\_\_\_\_

## MEDICATION

MEDICATION	DOSE	ROUTE	FREQUENCY
Actemra	<input type="checkbox"/> 4 mg/kg <input type="checkbox"/> 8 mg/kg <input type="checkbox"/> Other: _____	<input type="checkbox"/> IV	<input type="checkbox"/> Every 2 weeks <input type="checkbox"/> Every 4 weeks <input type="checkbox"/> Every ____ weeks

New Start Therapy     Continuation of Therapy    Date of last dose (if applicable): \_\_\_\_\_

## LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS:  NH: 603.217.5371     ME: 207.407.7272

Order valid for 1 year from date of signature unless otherwise specified here: \_\_\_\_\_