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	❑ 4 mg/kg ❑ 8 mg/kg ❑ Other: _______	❑ IV	❑ Every 2 weeks ❑ Every 4 weeks ❑ Every ____ weeks

❑ New Start Therapy ❑ Continuation of Therapy Date of last dose (if applicable): ______________

LABS / SPECIAL INSTRUCTIONS

FAX NUMBERS: ❑ CT: 203.433.0621 ❑ ME: 207.407.7272 ❑ NH: 603.217.5371 ❑ NJ: 201.581.4521

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