

☐ **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



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

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

☐ **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

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

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



(tocilizumab)

ACTEMRA infusion orders

Date: _____

Patient Name _____ DOB _____

Phone _____ MO FO

NPI _____ Tax ID _____

Insurance Carrier (primary) _____

Insurance Carrier (secondary) _____

DIAGNOSIS Please provide ICD-10 code

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

PRE-MEDICATION

- | | |
|--|---|
| ☐ Tylenol 1000mg PO | ☐ Solu-Medrol 125mg IVP |
| ☐ Cetirizine 10mg PO | ☐ Solu-Cortef 100mg IVP |
| ☐ Diphenhydramine 25mg PO | ☐ 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

PATIENT WEIGHT

_____ lbs.
_____ kg

NOTES

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____