

Los Angeles, CA  
2080 Century Park East  
Suite 710  
Los Angeles, CA 90067



(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**

Tylenol 1000mg PO                       Solu-Medrol 125mg IVP  
 Diphenhydramine 25mg PO               Solu-Cortef 100mg IVP  
 Cetirizine 10mg PO                         Diphenhydramine 25mg IVP  
 \_\_\_\_\_ (other)                               \_\_\_\_\_ (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 \_\_\_\_\_