Vermont
28 Park Ave
Suite #1A
Williston, VT 05495

ThrIVewell™ INFUSION

Mission Medical

Office: 212-803-3339 Fax : 646-768-8600

(tocilizumab)

ACTEMRA

Infusion orders

Date: _____

PATIENT INFORMATION

Name:	DOB:	SEX: M ☐ F ☐
ICD-10 code (required):	ICD-10 description:	
☐ NKDA Allergies:		Weight lbs/kg:

REFERRAL STATUS

☐ New Referral ☐ Referral Renewal ☐ Medication/Order Change ☐ Benefits Verification Only ☐ 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
- ☐ Diphenhydramine 25mg PO
- ☐ Cetirizine 10mg PO
- ☐ _____ *(other)*
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(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 evry 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 _____