

Fairfield
1817 Black Rock Turnpike
Suite 204
Fairfield, CT 06824

Greenwich
469 W Putnam Ave
Ste 205,
Greenwich, CT 06830



(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 <i>Please provide ICD-10 code</i>	
☐ _____ 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 _____