

Lexington
1792 Alysheba Way
Suite 205
Lexington, KY 40509

Bowling Green
727 U.S. 31 W Bypass
Suite 102
Bowling Green, KY 42101



(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 <table border="0"><tr><td>☐ Tylenol 1000mg PO</td><td>☐ Solu-Medrol 125mg IVP</td></tr><tr><td>☐ Diphenhydramine 25mg PO</td><td>☐ Solu-Cortef 100mg IVP</td></tr><tr><td>☐ Cetirizine 10mg PO</td><td>☐ Diphenhydramine 25mg IVP</td></tr><tr><td>☐ _____ (other)</td><td>☐ _____ (other)</td></tr></table> SPECIAL INSTRUCTIONS 	☐ Tylenol 1000mg PO	☐ Solu-Medrol 125mg IVP	☐ Diphenhydramine 25mg PO	☐ Solu-Cortef 100mg IVP	☐ Cetirizine 10mg PO	☐ Diphenhydramine 25mg IVP	☐ _____ (other)	☐ _____ (other)	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
☐ Tylenol 1000mg PO	☐ Solu-Medrol 125mg IVP								
☐ Diphenhydramine 25mg PO	☐ Solu-Cortef 100mg IVP								
☐ Cetirizine 10mg PO	☐ Diphenhydramine 25mg IVP								
☐ _____ (other)	☐ _____ (other)								

NOTES/ADDITIONAL COMMENTS:

ORDERING PROVIDER

Signature X _____ Date _____

Provider _____ Phone _____ Fax _____