(tocilizumab)

ACTEMRA infusion orders

Patient Name _____ DOB _____

Phone _____ M ◯ F ◯

DIAGNOSIS *Please provide ICD-10 code*

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

PRE-MEDICATION

- ☐ Tylenol 1000mg PO
- ☐ Cetirizine 10mg PO
- ☐ Diphenhydramine 25mg PO
- ☐ _____
- ☐ Length of Need _____
- ☐ Solu-Medrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Diphenhydramine 25mg IVP
- ☐ _____ *(other)*

ACTEMRA ORDERS

DOSAGE

- ◯ Initial dose of 4mg/kg every 4 weeks for _____ treatments then 8mg/kg every 4 weeks *(induction dosing)*
- ◯ 4mg/kg every 4 weeks
- ◯ 8mg/kg every 4 weeks
- ◯ Refills: _____

PATIENT WEIGHT

_____ lbs.

_____ kg

Notes

_____

ORDERING PROVIDER

Signature **X** _____ Date _____

Provider _____ Phone _____ Fax _____

Address _____

_____

NPI# _____

DEA# _____

FAX ORDERS: 702-780-4887