



Actemra (tocilizumab) ORDER FORM

Prerequisites to treatment – ensure the following information is complete and attached with referral: [ ] Demographics [ ] Prior Authorization [ ] Office/Progress Notes

PATIENT INFORMATION

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_ [ ] Male [ ] Female
Phone Number: \_\_\_\_\_ Allergies: \_\_\_\_\_

DIAGNOSIS

[ ] Rheumatoid Arthritis (RA) ICD 10: \_\_\_\_\_
[ ] Giant Cell Arthritis (GCA) ICD 10: \_\_\_\_\_
[ ] Other: \_\_\_\_\_ ICD 10: \_\_\_\_\_

PRE-MEDICATION

[ ] Tylenol 1000mg PO [ ] Solu-Medrol 40mg IVP
[ ] Cetirizine 10mg PO [ ] Solu-Medrol 125mg IVP
[ ] Diphenhydramine 25mg PO [ ] Other: \_\_\_\_\_

MEDICATION

Actemra

Dosing: [ ] IV \_\_\_\_\_ mg
Duration: [ ] IV Infusion over 1 hour OR [ ] IV Infusion over \_\_\_\_\_ hours
Frequency: [ ] Every 4 weeks OR [ ] Other: Every \_\_\_\_\_ weeks
Route: [ ] Peripheral IV per protocol [ ] PICC capping per protocol [ ] PORT capping per protocol
[ ] Monitor vitals baseline and post infusion
[ ] Other: \_\_\_\_\_

[ ] New Start [ ] Continuation of therapy [ ] Date of Last Dose (if applicable) \_\_\_\_\_

**REFERRING PROVIDER INFORMATION**

For questions regarding patient's care during the infusion, please contact:

Facility: \_\_\_\_\_ Fax: \_\_\_\_\_

Name 1<sup>st</sup> Point of Contact (must be available during infusion): \_\_\_\_\_

Phone: \_\_\_\_\_

Name 2<sup>nd</sup> Point of Contact (must be available during infusion): \_\_\_\_\_

Phone: \_\_\_\_\_

*By referring to the Medical Associates Infusion Clinic, it is recognized and agreed upon that the referring specialist or delegate listed above will be available and responsive during the duration of the scheduled infusion appointment. This contact should be available to answer any questions and/or address concerns related to the care of the patient. The on-site provider within the Infusion Clinic will be responsible for urgent patient care needs during the infusion.*

Ordering Provider Name (please print): \_\_\_\_\_

Ordering Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**FAX NUMBER: 563-584-4232**

**PHONE NUMBER: 563-584-4370**

Order valid for 1 year from date of signature unless otherwise specified.