○ New Prescription/Referral
○ Prescription Refill

ACTEMRA (tocilizumab)

Rx:

Patient Name:

DOB:

MEDICATION/Strength: **ACTEMRA (tocilizumab)**

ROUTE:
- ☐ Peripheral IV
- ☐ PICC
- ☐ Midline
- ☐ Port
- ☐ SubQ
- ☐ IM

- ○ 4mg/kg q4 wks for _____ treatments
  - ☐ then 8mg/kg q4 wks
- ○ 4mg/kg q4 wks
- ○ 8mg/kg q4 wks
- ○ Others:

Dx:
- ○ Rheumatoid Arthritis (M06.9)
- ○ Giant Cell Arteritis (M31.6)
- ○ Polyarticular Juvenile Idiopathic Arthritis (M08.3)
- ○ Systemic Juvenile Idiopathic Arthritis (M08)
- ○ Cytokine Release Syndrome (D89.83)
- ○ Others (**Dx + ICD Code 10**):

Pre-Medication:
- ☐ Solumedrol 125mg IVP
- ☐ Solu-Cortef 100mg IVP
- ☐ Others:
- ☐ Tylenol _____mg PO
  - ☐ 650mg ☐ 975mg
- ☐ Benadryl _____mg
  - ☐ 25mg ☐ 50mg
  - ☐ IV ☐ PO

ANA Kit Protocol:
- ☐ OK to use

NPI#:

DEA#:

Physician Signature

Date: (Valid for 1 year)

PHYSICIAN INFORMATION

Physician Name:

CLINIC:

Contact Information:

Phone:

Fax:

Email:

Other:

Office Mailing Address:

Check that the following are included:
- ☐ **Patient demographics & Insurance attached**
- ☐ **Clinical progress notes**
- ☐ **History and Physical**
- ☐ **Lab Results**
- ☐ **Other Test Results**
- ☐ **Diagnosis (supporting)**
- ☐ **Medication List**