

ACTEMRA (Tocilizumab)



215 Pleasant Street, 5th Floor, Fall River, MA 02721
Phone: (508) 567-5666 | Fax: (508) 567-5614

PATIENT DEMOGRAPHICS

Patient Name:	Patient's Phone Number:
Date of Birth:	Address:
Allergies: See List <input type="checkbox"/> NKDA <input type="checkbox"/>	City, State, Zip:
Weight: _____ lbs or _____ kg	Patient's Email:

REQUIRED DOCUMENTATION

<input type="checkbox"/> Insurance Card	<input type="checkbox"/> H&P	<input type="checkbox"/> Patient Demographics	<input type="checkbox"/> Baseline LFTs and Lipid Panel	<input type="checkbox"/> Medication List
TB Test	Date: _____	Results: _____		
Absolute Neutrophil Count	Date: _____	Results: _____	HCV: Date: _____	
Platelet Count	Date: _____	Results: _____	Results: _____	
HBV	Date: _____	Results: _____		

PRIMARY DIAGNOSIS

M31.6 Other giant cell arteritis
 M06.09 Rheumatoid arthritis without rheumatoid factor, multiple sites
 M06.9 Rheumatoid arthritis, unspecified
 M06.00 Rheumatoid arthritis without rheumatoid factor, unspecified site
 Other: _____

LAB ORDERS: PLEASE INCLUDE FREQUENCY

CBC w/ diff & ANC: _____ LFT's at month 2 then every 3 months after Other: _____

PRE-MEDICATIONS (15 - 20 MINS BEFORE INFUSION)

Diphenhydramine 25mg PO or IVP & 50mg PO or IVP Cetrizine 10mg PO Pepcid 20mg PO or IVP
 Solu-Medrol 40mg IVP Solu-Cortef 125mg IVP Tylenol 650mg PO Other: _____

PRIMARY MEDICATION ORDER

Actemra 4mg/kg (fixed dose _____ mg) IV every 4 weeks if tolerated well increase to 8mg/KG infuse over 1 hour
 Actemra 6mg/kg (fixed dose _____ mg) IV every 4 weeks if tolerated well increase to 8mg/KG infuse over 1 hour
 Actemra 8mg/kg (fixed dose _____ mg) IV every 4 weeks if tolerated well increase to 8mg/KG infuse over 1 hour

Other: _____

First Dose: Y N Refill x12 months unless otherwise noted: _____

LINE USE/CARE ORDERS

Start PIV/ACCESS CVC Flush device per Suite Life Health's protocol (See suitelifehealth.com for detailed policy)
 Other Flush Orders: Please fax other line care orders if checking this box

ADVERSE REACTION & ANAPHYLAXIS ORDERS

Administer acute infusion and anaphylaxis medications per Suite Life Health's protocol (See suitelifehealth.com for detailed policy) Other: Please fax other reaction orders if checking this box

PROVIDER INFORMATION: PLEASE CHECK PREFERRED FORM OF COMMUNICATION

Provider Name:	Office Contact:
Address:	Phone:
City, State, Zip:	<input type="checkbox"/> Fax:
NPI AND License:	<input type="checkbox"/> Email:

Provider Signature _____

Date _____

