PRESCRIPTION ORDER FORM

ACTEMRA
(Tocilizumab)

Suite Life
Infusing health and wellness into your life.
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 ☐ NKDA ☐	City, State, Zip:
Weight:_____lbs or _____kg	Patient's Email:

REQUIRED DOCUMENTATION

• Insurance Card • H&P • Patient Demographics • Baseline LFTs and Lipid Panel • Medication List

• TB Test Date:_____ Results: _____
• Absolute Neutrophil Count Date:_____ Results: _____
• Platelet Count 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 Rheumatoiad 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:	☐ Fax:
NPI **AND** License:	☐ Email:

Provider Signature _____ Date _____