***Patient Insurance & ID (front and back) are needed**

○ New Prescription/Referral
○ Prescription Refill

ACTEMRA (tocilizumab)

Rx:

Patient Name: Patient Weight: lbs **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)

By affixing my signature, I confirm the medical necessity of the aforementioned therapy, products, and services, as well as my responsibility for the patient's care. I have obtained consent to disclose the mentioned details and any relevant medical or patient information concerning this treatment. I grant the pharmacy permission to contact the insurance company on my behalf to secure authorization for the patient.

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** (supporting)
☐ **History and Physical**
☐ **Lab Results**
☐ **Other Test Results**
☐ **Diagnosis (supporting)**
☐ **Medication List**
☐ CBC w/diff, LFTs, Lipid Panel (attach results)
☐ TB test Results within 12 months
☐ Hep B surface antigen Results

*If TB or Hepatitis B results are positive - please provide documentation of treatment or medical clearance, and a negative CXR (TB+)