eMediateINFUSION center

- ○ 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
- ☐ Tylenol _____mg PO
  - ☐ 650mg ☐ 975mg
- ☐ Benadryl _____mg
  - ☐ 25mg ☐ IV
  - ☐ 50mg ☐ PO
- ☐ Others:

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

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