○ 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+)