Actemra Order
(Tocilizumab)

SMART CHOICE INFUSION
FOR YOUR HEALTH & WELLNESS

www.smartchoiceinfusion.com
Ph: 818-659-8182
Fax: 818-659-8990

Date: _____ Treatment Location: _____

***Please fax a copy of the following patient information:** ❒ Demographics ❒ Insurance Information ❒ Current CBC & CMP ❒ H & P Relevant to the Diagnosis ❒ Current Medications ❒ TB Results

PATIENT INFORMATION

Patient Name: _____

DOB: _____

Allergies: _____

Weight: _____ ○ lbs / ○ kg Height: _____

Diagnosis: _____

ICD-10: _____

PROVIDER INFORMATION

Printed Provider's Name: _____

Signature: _____

NPI: _____ Date: _____

Phone: _____ Fax: _____

Office Address: _____

Contact Person: _____

TB TEST / CHEST X-RAY

Result: _____ Test Date: _____ ❒ Copy Attached

PRE-MEDICATIONS: *(USUALLY NOT INDICATED)*

Benadryl: ❒ PO ❒ IV ❒ 25mg ❒ 50mg ❒ Pre-med ❒ PRN

Acetaminophen: ❒ 325mg ❒ 650mg ❒ Pre-med ❒ PRN

ACTEMRA (TOCILIZUMAB) IV DOSAGE

Date of Last Treatment, If Continuation:

Maximum Dose is 800mg

❒ 4mg/kg ❒ 8mg/kg Every ❒ 4 weeks or ❒ 2 weeks Total dose: _____ mg

Start Date of Infusion: _____